# STRENGTHENING REPROSALUD'S MONITORING AND EVALUATION STRATEGIES

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The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of POPTECH, BHM International, The Futures Group International, or the staffs of those organizations.

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**APPENDICES**

# ABBREVIATIONS

| | |
|---|---|
| CBO | Community-based organization |
| DHS | Demographic and Health Survey |
| HOPARGEN | *Participación del hombre/pareja en actividades generales de ReproSalud* |
| ENDES | *Encuesta Demografica y de Salud Familiar* |
| IEC | Information, education, and communication |
| INEI | *Instituto Nacional de Estadistica e Informatica* |
| IR | Intermediate Result |
| MEU | Monitoring and Evaluation Unit |
| MOH | Ministry of Health |
| MMR | Movimiento Manuela Ramos |
| MUACSECO | *Aceso de la mujer a recursos económicos* |
| MUPARDES | *Participación de la mujer en desarrollo de destezas* |
| MUPARGEN | *Participación de la mujer en actividades generales* |
| NGO | Nongovernmental organization |
| PASARE | Program of Support in Reproductive Health (*Programa de Apoyo en Salud Reproductiva*) |
| POPTECH | Population Technical Assistance Project |
| RCC | Regional Coordinating Committees |
| USAID | U.S. Agency for International Development |

# ACKNOWLEDGMENTS

The POPTECH Team is indebted to many individuals who provided us with background information, access to on-going project activities, and logistical support that made our assignment possible. We thank individuals at USAID's Office of Health and Population and the staff at ReproSalud's central and regional offices for meeting with us and providing us with support. These and other informants are listed in Appendix C.

Special gratitude is owed to Anna Britt Coe, who helped us in a number of important ways, for which we are indebted. She translated for one Team member at all meetings and instructed the whole Team on ReproSalud's structure and project implementation process. Without her, it would have taken us longer to fully grasp the project activities. Finally, she contributed to the section on empowerment and advocacy in this report. The Team is also appreciative of Helena Manrique's assistance in overseeing our schedules and logistic requirements.

# SUMMARY OF SCOPE OF WORK

The following guidelines for the Team's Scope of Work were submitted to the Team by the Technical advisor to ReproSalud (Feringa, 1997). The full Scope of Work submitted to the Team is presented in Appendix A.

1. The overall focus of the Team's work should be on design issues. The recommendations for monitoring and evaluation should be technically sound and should include a discussion of the following:
   - The technical and managerial requirements of suggested evaluation plans
   - ReproSalud's capacity to implement the evaluation plans that were suggested
   - The stakeholder's perceived needs
   - The costs

2. Examples of the types of questions to be addressed include the following:
   - How will evaluation standards be maintained without compromising flexibility?
   - Are control groups necessary for an impact study? If so, what are the criteria for choosing controls? Relative costs? What constraints would implementing this approach have on project activities?
   - What are the best ways for evaluating empowerment?
   - With respect to international stakeholders, what project activities will be most interesting to evaluate? How feasible will it be to meet the rigorous standards of international audiences?
   - Are the indicators used thus far appropriate? What other indicators could be added? Which indicators should be regularly monitored? Which can be included only in occasional data collection efforts?
   - How effective are the current survey instruments in addressing the project's evaluation needs?

3. The Mission requested that the Team's findings and recommendations be presented as options and alternatives for informed decision making.

4. A debriefing was requested to discuss the main findings with USAID and the ReproSalud staff. Different members of the Team held three such debriefings. Two were held at USAID and one at the offices of Movimiento Manuela Ramos.

# EXECUTIVE SUMMARY

ReproSalud is an innovative reproductive health project. It was conceived to address constraints that have limited the effectiveness of other USAID projects that attempt to improve the quality and use of health services in Peru. A five-year project initiated in 1996, ReproSalud targets rural and periurban women in eight regional departments. All project activities have a gender focus, involve participation by the community, attempt to strengthen women's individual and group skills, and improve the capacity of community-based organizations (CBOs) and their members. The project is being implemented by Movimiento Manuela Ramos (MMR), a dynamic woman's advocacy group, and is viewed by international population and women's groups as a unique experiment to implement the Cairo plan. Thus, apart from the normal requirements to monitor and evaluate the project, proof of the project's impact will have to be based on high standards that address the needs of the international community.

A four-member Team was contracted by POPTECH[1] to provide technical assistance to ReproSalud in its efforts to monitor and evaluate the project. In particular, the Team was asked to propose options for the design of an evaluation plan, and to suggest additional indicators and instruments for monitoring and evaluating the most innovative aspects of the project. These components include the use of participatory methods, a focus on women's empowerment, and the relationship between participation in microenterprises and changes in reproductive health behavior. The Team reviewed project documents, interviewed key members of USAID/Peru and ReproSalud staff, visited on-going activities at several project sites, and examined the evaluation activities in progress. Two members of the Team also met with researchers and policy planners in Washington, D.C., to identify more specifically the needs of international stakeholders.

## Accomplishments in Monitoring and Evaluation to Date

The project has generated an extensive amount of data since its inception, much of which is associated with the design and piloting of diagnostic tools and project implementation methods. While not developed for evaluation purposes per se, this information can be used to describe the innovative methodologies being used by the project. Examples include situational analyses of the districts, transcripts from *autodiagnóstico* sessions in which women discuss their health concerns, and evaluations of the success of the individual subprojects. More formally, a number of small, targeted studies are proposed that will be conducted by outside consultants. One of these studies aims to determine the prevalence and causes of genital tract infections as well as to establish the prevalence of abnormal pap smears in areas where ReproSalud is working. The first effort to evaluate ReproSalud projectwide is a recently completed baseline survey of all communities participating in first-round projects.

[1] The Team included Dr. Jill Posner (head), Dr. Amalia Alberti, Dr. Deborah Caro, and Dr. Sidney Schuler.

The evaluation unit has been functioning for only six months and has accomplished a great amount in a short time. The pressure to "hit the ground running" may have contributed to problems observed in the design of the baseline survey. The Team believes that the Coordinator of the Monitoring and Evaluation Unit (MEU) and other social science researchers involved in project implementation have a good understanding of the complexities inherent in monitoring and evaluating this project. The coordinator and researchers are committed to achieving high standards in data collection.

**Evaluation Strategies**

A critical tool for evaluation is a well-developed Results Framework that identifies all components of the project and explains how they are hypothesized to produce desired outcomes. Although project staff members had developed main hypotheses, an integrated framework for expected results did not exist. Using the project's strategic objective and the main hypotheses, Team members worked on creating a preliminary Results Framework. With fine-tuning, this model should be helpful in identifying indicators that can be used to measure outcomes.

Team members also examined and provided options for evaluation in four specific areas: (1) women's empowerment and its relation to reproductive health, (2) microenterprises and credit, (3) the *autodiagnóstico* method as a tool for research, and (4) the design of a quantitative impact study.

With respect to empowerment, a small set of indicators was distilled from the baseline questionnaire. They are unambiguous and relate directly to the Results Framework. To describe the existing situation, we propose an ethnographic baseline survey. Also identified as important, in light of the confusion registered by some international observers, is a complete documentation of ReproSalud's objectives and methods. Finally, qualitative and quantitative research would be conducted at particular points in time to document changes that occur in empowerment, changes that relate to health, and links between the two domains.

It was more difficult to identify acceptable indicators that reflect the impact of the micro-enterprise and credit components. It will be necessary for the project staff to consider alternatives. Several more general indicators related to income generation and microfinance were identified. Among other things, the restricted time frame and small increases in income generated may inhibit detecting changes in reproductive health behaviors, the main indicator of the project's impact. Instead of measuring success in these terms, it may be more relevant to examine how participation in these components enhances women's negotiation skills and self-esteem, and thereby influences (1) the incidence of domestic violence, (2) the ability to negotiate the time and place of sexual relations, and (3) changes in the use of birth control. A combination of qualitative and survey research could be used to do this.

The effects of advocacy at the local level have not been documented in any systematic way. Although some examples of women's lobbying activities are available in monthly reports, others probably go unrecorded. It will be important to implement standard ways of recording women's efforts at advocating for their rights and needs, and options are suggested in the body of the report. If one is to document changes that occur in the status quo resulting from advocacy, a description of the situation that existed before ReproSalud began working in the community is needed. For this, the project should also conduct an ethnographic baseline survey in selected communities.

The *autodiagnóstico* method was not designed to be a research tool, but has the potential to prove valuable qualitative information about women's understanding and beliefs about their own health and well-being. The *autodiagnóstico* generates extremely rich qualitative data that will be of great interest and value both within and outside of Peru; however, questions about the validity and reliability of this approach will have to be addressed. Suggestions for strengthening this methodology are suggested in the report.

A comprehensive design for a projectwide impact study has not been elaborated. The baseline survey was a first step, but a number of critical design issues must still be resolved. Foremost among them are sampling and whether to include control groups. The current baseline survey included all communities involved in the project. If one is to reduce costs and contain the amount of data collected, a sampling procedure should be adopted. This report provides a model that can be adopted or revised. The decision to use control groups must emerge from the needs of the project. While selecting control groups will not be straightforward, we believe that using a quasi-experimental design with controls is important both in terms of documenting changes that occur and satisfying international stakeholders. Also important is the gender focus of this project, which may be best evaluated using periodic assessments of the same women over time. Such assessments would involve one or more panel studies of women in CBOs. The Team endorses both of these approaches to evaluation and suggests a plan for integrating the two types of studies.

Two overarching concerns that affect evaluation are the selection of the women participating in the project and the degree of involvement of the project staff in the communities. The effect of these factors will have to be addressed. Quantifying the degree of participation that different community members have in project activities is one way of addressing selection effects, but other problems related to the selection process that indirectly affect outcomes will not be easy to resolve. These problems include the advanced age of some members and the educational status of others, which might limit demonstrating change in key reproductive health indicators such as use of modern contraceptives.

Finally, ReproSalud's MEU will need to be expanded if the project hopes to carry out the approaches suggested by this Team. While contracting survey teams and statistical support is feasible, the unit requires one or more additional social scientists with expertise in evaluation methods to respond reputably to the demand for high-quality data.

# SUMMARY OF KEY RECOMMENDATIONS

## Results Framework

- A well-developed Results Framework that represents the diverse components of the project and indicates how they are expected to lead to project outcomes is essential for monitoring and evaluation. The absence of such a framework was considered to be a major lacuna that the team addressed by elaborating a preliminary framework for consideration by the ReproSalud staff. Although the Team revised the Results Framework according to the response of the ReproSalud staff, the framework requires additional fine-tuning. We recommend that project staff members devote time to accomplishing this task.

## Indicators

- Provisional suggestions for indicators that reflect the main Intermediate Results (IR) were recommended by the Team and appear in Appendix D. The next step in the elaboration of a monitoring and evaluation plan for each Intermediate Result will include determining (1) a set of unambiguous indicators, (2) targets for achieving them, (3) baseline values, (4) sources of data for each, (5) the timing of the data collection for each, and (6) the cost. The Team devised a convenient matrix for use in determining each of these factors (Table 1, p. 9).

## Strategies for Evaluating Empowerment and Reproductive Health

- A plan for evaluating the effects of the ReproSalud project on women's empowerment and reproductive health should include the following tasks:

  - Documentation of the existing situation against which project impact is to be measured. This documentation can be done by constructing an ethnographic baseline and by conducting a baseline survey. The description could be organized in terms of indicators of empowerment and disempowerment and of reproductive health.

  - Detailed description of the ReproSalud project, both as designed and as implemented. This description will be important for international audiences who do not have a clear understanding of what the project intends to do and what it is actually doing. It will also be important to highlight the fact that all of the subprojects in the initial years of implementation focus on community-level education.

  - Qualitative and survey research to assess changes in women's empowerment in project sites and to document linkages between empowerment and reproductive health.

- The evaluation plan should be open ended enough to document unforeseen outcomes. Although it will be important to maintain a certain amount of flexibility, it will also be important to focus the evaluation on a manageably small set of empowerment outcomes that have the following characteristics:
  - Likely to occur within the time frame in which they are being assessed,
  - Feasible to assess,
  - Clearly related to the project's Results Framework, and
  - Relevant across project sites (if used in statistical analyses).

- Reproductive health indicators that are most likely to show an impact over the short run should be selected. The reproductive health indicators should focus on individual knowledge, attitudes and health-seeking behaviors, group activities to improve health, and individual and group interactions with health services and policy makers, rather than on health impacts that are difficult to measure in small populations or on those impacts that may require a long period of time to come about (e.g., longer birth intervals).

- In the existing baseline survey instrument, potentially ambiguous questions should be eliminated, as well as those that probably will not be useful for evaluating the impact of ReproSalud on women's empowerment and reproductive health. For example, we would eliminate most of the section on income generation and, instead, carry out in-depth case studies in selected sites where ReproSalud has established village banks or microenterprise interventions.

- Many questions in the baseline survey related to women's participation in decision making, control over income, and division of labor by gender should be revised or eliminated because they are too general and may generate normative responses.

**Effects of Microcredit and Income-Generating Activities**

- Demonstrating that credit and income-generating activities will have an impact on women's reproductive health will be difficult for a number of reasons, including a short time frame. Because the project must show changes in the short term, it may be necessary to use proxy indicators of changes in behavior rather than demonstrated changes, particularly where relatively small numbers of cases are available, such as in the income-generating activities (approximately 200 women in nine banks).

- ReproSalud should reconsider the purpose of the income-generating component in its programmatic sequence. If the primary purpose of the project is to improve women's reproductive health behaviors, then the process—and the skills learned in that process—may be far more important than the extent to which women's incomes are increased. If that is so, then the ReproSalud staff members may need to put greater emphasis on the specific skills that women need to learn to produce the smaller, more measurable-in-the-short-term,

intermediate results leading to the desired long-term changes in their reproductive health behavior.

### Advocacy at the Local Level

- ReproSalud should develop systematic ways of documenting the effects of advocacy such as having (1) a roving researcher who visits as many different sites at the community level as possible to document the activities being conducted and their effects, (2) each region report on and describe in detail an advocacy activity and its outcome as a standard inclusion in its monthly report, and (3) staff members routinely talk into a tape recorder on their rides home from project activities to record any noteworthy incidents that they witnessed or heard about that occurred as a result of advocacy activities. Documentation of advocacy activities and their outcomes will provide the project with a database of different approaches and responses. Analysis of this information will yield insights into which approaches are most effective in specific contexts.

- To measure changes in advocacy, ReproSalud should construct a baseline that represents women's relationship with health services and gender relations in the community before ReproSalud's intervention. The following kinds of information can be used: situational analysis, forms completed by CBOs that describe their prior activities, and thematic extractions from the *autodiagnóstico* sessions on gender issues and women's perceptions and relations with health services.

### Baseline Survey Methods and Impact Design Plan

- Sites where the first-round subprojects were undertaken (all of which were included in the current baseline sample) varied greatly in size. Additional thought should be given to what constitutes the "community" in different zones. Also, the size of communities should be taken into consideration when sampling villages.

- Some of the proposed baseline data were collected after the initiation of the main interventions. Not only is it unreasonable to consider individuals who have participated in educational training workshops on reproductive health as having a baseline understanding, but also it would prejudice demonstrating project impact at a later time. Surveys collected after training in reproductive health began should not be included in the baseline sample.

- "Community" was not surveyed in urban areas with populations greater than 2,000, because "community" was not easily determined. Thus, project effects cannot be assessed at this level. We recommend asking CBO members to describe the community they think they represent (and where they are located) during the selection process. In cases where the CBO members

cannot delimit a specific zone because the community is dispersed across a populated area, sampling two of the members' neighbors might represent a reasonable proxy.

Many aspects of an overall design for an evaluation study have not yet been specified. We suggest several options:

- A sampling plan that reduces the number of sites represented in the sample is recommended. It is not cost-effective, nor is it necessary from a statistical point of view, to survey all sites as has been done to date. Subprojects initiated in 1998 (and those sampled before project activities began in 1997) could be considered the sampling frame. From this population, a smaller number of sites would be selected that would constitute the baseline sample. Methods are proposed for determining the number of sites.

- Whether to use control groups in the evaluation design is an issue that has concerned project staff members and others interested in the project from the outset. The decision should be based on what the evaluation attempts to demonstrate and what constraints must be overcome in designing a valid study. Including a control group would improve the ability to determine the differential effect for ReproSalud groups over and above the control groups. Despite the challenge of selecting "matched" control groups, we recommend adopting a design that includes external control groups and also conducts panel studies (with some of the same women who will be sampled in the baseline-endline study) that examines changes in women's groups over time.

**Overarching Considerations**

- The screening process for the selection of CBOs to participate in the project is highly selective, because it attempts to identify the most dynamic and organized women's groups in a district. Within such groups, women having greater leadership potential, more disposable time, and probably higher literacy rates are further selected as participants in the programmatic sequence of ReproSalud. How representative of the project's target population are the women who become most directly involved in ReproSalud's program? Factors such as advanced age and prior use of contraceptive methods (before ReproSalud's intervention among the women most directly involved in the programmatic sequence) may limit the actual impact on variables such as contraceptive prevalence. A more in-depth study addressing the effects of the selection process and group membership should be undertaken as soon as possible in one or more communities. If the concern about representativeness is shown to be warranted, steps should be instituted as quickly as possible to address this concern.

- The success of the project depends on continued interaction with the ReproSalud regional teams. As regional team members withdraw and as promoters are left in charge, it is unclear whether the promoters will be capable enough to organize subsequent subproject designs that address new topics. Also unclear is whether the community will regard the promoters with the

same confidence and whether the promoters will continue to receive financial incentives for their time. To show impact, it is recommended that the baseline survey be re-administered at regular intervals before completion of the ReproSalud project. The impact of the project in terms of prompting change in behavior may be greatest around the time of the completion of the first subproject. After that time, the regional teams are likely to be less directly involved with the community, and the effects may lessen.

- The MEU of the project has a limited staff and will have to be strengthened if high-quality research of the type recommended in this report is a goal. We recommend increasing the staff by hiring social scientists who have qualitative and quantitative experience in evaluating the diverse components of the project.

# 1. STRENGTHENING REPROSALUD'S MONITORING AND EVALUATION STRATEGIES

## 1. Introduction and Project Background

ReproSalud was designed to address the constraints that limited the effectiveness of other USAID projects to improve the quality and coverage of service delivery in Peru. Reproductive health services in the country operate far below capacity, and unmet need—as measured by the Demographic and Health Surveys (DHS)—has not translated into a demand for women's reproductive health services in rural and periurban areas.

In examining the reasons for this apparent contradiction, the Mission's Health and Population Office identified a number of critical sociocultural factors that had been ignored by other projects, such as gender relations; concepts of self and body; and differences in ethnicity, language, class, and culture between the largely indigenous population and health care providers. The Mission staff members concluded that to reach women who have been reluctant to use health services, they would have to work with them on their own terms and within their own social groups.

It was on this principle that the ReproSalud project was conceived. The project works with community-based organizations (CBOs) representing various women's groups. The project seeks to improve reproductive health and to address women's strategic gender needs in economically disadvantaged rural and periurban areas. It provides support to women's groups in three broad areas: reproductive health, income generation, and advocacy. One of its central underlying assumptions is that, in marginalized communities, reproductive health is constrained not only by supply-side factors, such as the availability of reproductive health services and service quality, but also by gender inequities and disempowerment.

Implicit in the project design is the assumption that empowering interventions with groups of women will stimulate empowerment processes at various levels: in the individual psyche, within the family, and within women's groups and communities, as well as beyond the community in relationships with health services and policy makers. In the logic of the ReproSalud project, empowerment must occur at these various levels, not just at the level of the individual, if the anticipated positive effects on reproductive health are to come about. ReproSalud is, therefore, a complex and ambitious project, and the task of evaluating its impact will be complicated and challenging. Assuming the evaluation is well documented and methodologically sound, the results should be of great interest both within Peru and internationally, because so little has been done so far to document the implementation of the Cairo agenda.

The Mission contracted the POPTECH Team to review and strengthen ReproSalud's monitoring and evaluation strategies. The Team based its conclusions on a comprehensive examination of project documents, discussions with the director of the USAID Health and Population Office and the technical advisor to ReproSalud, meetings with the ReproSalud project staff in Lima and in

two regional offices, interviews with other experts who are involved in various aspects of the project, and several brief visits to the field to observe on-going project activities. The rest of this report is divided into seven main sections: Chapter 2 is a proposed Results Framework that identifies expected outcomes from diverse project activities and suggests indicators for the Strategic Objective and Intermediate Results (IRs), Chapter 3 addresses indicators and evaluation strategies for women's empowerment and reproductive health, Chapter 4 gives indicators and evaluation issues for microenterprise and credit, Chapter 5 gives indicators and evaluation strategies for advocacy at the local level, Chapter 6 describes the *autodiagnóstico* method as a monitoring and evaluation tool, Chapter 7 explains the baseline survey and proposed plan for final and intermediate impact studies, and Chapter 8 contains general issues affecting monitoring and evaluation, as well as concluding remarks.

# 2. RESULTS FRAMEWORK

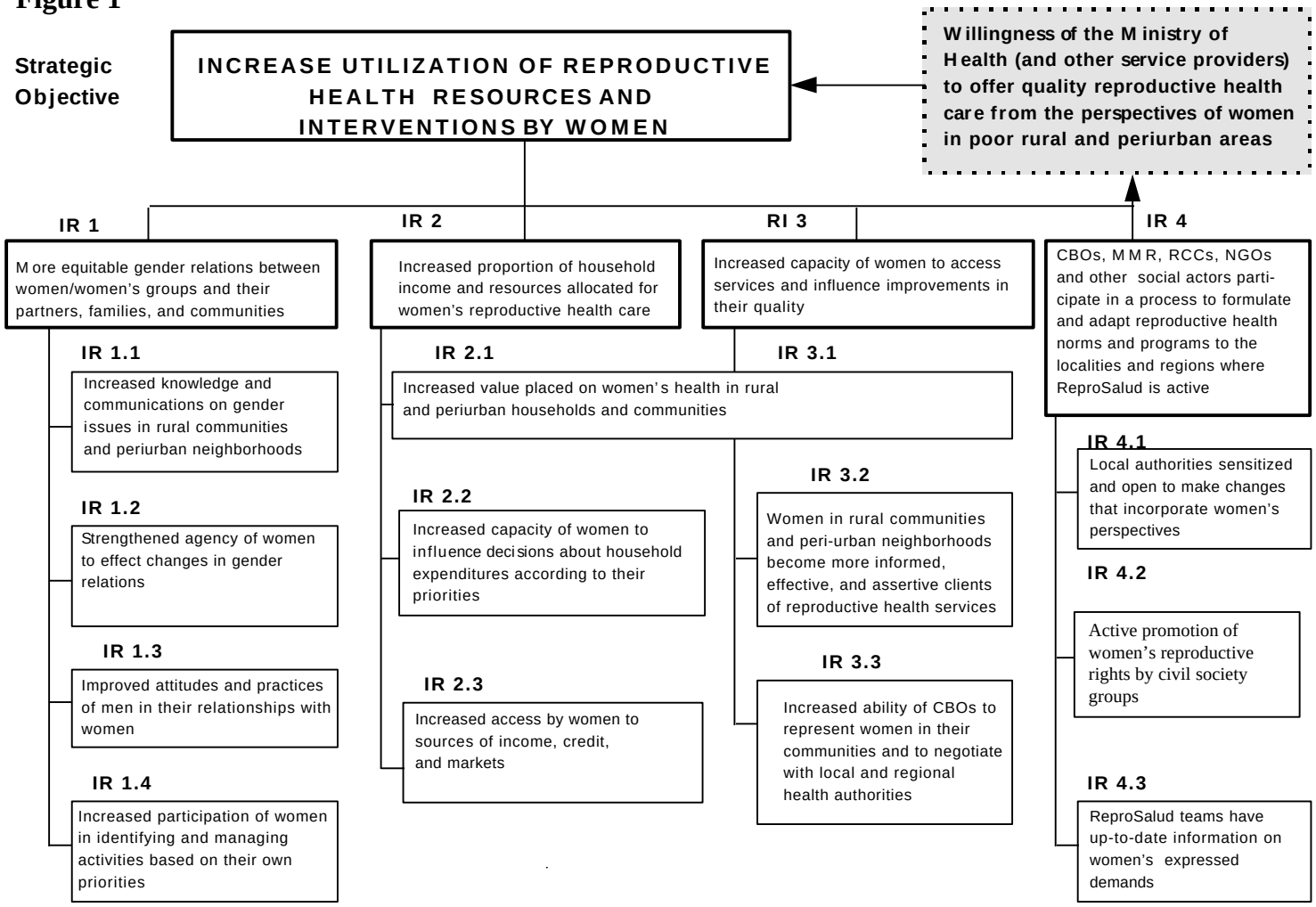
## 2.1 Background

The original Project Paper and later efforts (Brems et al., 1997) provided a general conceptual framework for ReproSalud, but did not integrate various project components into a comprehensive Results Framework that would lead to specific indicators of impact. Project staff members cited the lack of a well-developed Results Framework as an obstacle to developing an integrated evaluation plan. In response to this expressed need, members of the Team produced a preliminary Results Framework that was revised with key members of the ReproSalud staff. The framework presented here is still considered to be preliminary; it will undoubtedly need to be revised by ReproSalud. The basic principles guiding the project that we have tried to make explicit in the Results Framework are as follows:

- Gender focus,
- Support to the CBO for initiatives in reproductive health and income-generation,
- Training and technical assistance to strengthen individual and organizational skills,
- Sustainability of the initiatives supported by the project, and
- Flexibility.

The overall Results Framework is presented in Figure 1. Appendix D contains illustrative indicators for each of the Intermediate Results that appear in Figure 1.

**Figure 1**


Strategic Objective
INCREASE UTILIZATION OF REPRODUCTIVE HEALTH RESOURCES AND INTERVENTIONS BY WOMEN
Willingness of the Ministry of Health (and other service providers) to offer quality reproductive health care from the perspectives of women in poor rural and periurban areas
IR 1
More equitable gender relations between women/women's groups and their partners, families, and communities
IR 1.1
Increased knowledge and communications on gender issues in rural communities and periurban neighborhoods
IR 1.2
Strengthened agency of women to effect changes in gender relations
IR 1.3
Improved attitudes and practices of men in their relationships with women
IR 1.4
Increased participation of women in identifying and managing activities based on their own priorities
IR 2
Increased proportion of household income and resources allocated for women's reproductive health care
IR 2.1
Increased value placed on women's health in rural and periurban households and communities
IR 2.2
Increased capacity of women to influence decisions about household expenditures according to their priorities
IR 2.3
Increased access by women to sources of income, credit, and markets
RI 3
Increased capacity of women to access services and influence improvements in their quality
IR 3.1
IR 3.2
Women in rural communities and peri-urban neighborhoods become more informed, effective, and assertive clients of reproductive health services
IR 3.3
Increased ability of CBOs to represent women in their communities and to negotiate with local and regional health authorities
IR 4
CBOs, MMR, RCCs, NGOs and other social actors participate in a process to formulate and adapt reproductive health norms and programs to the localities and regions where ReproSalud is active
IR 4.1
Local authorities sensitized and open to make changes that incorporate women's perspectives
IR 4.2
Active promotion of women's reproductive rights by civil society groups
IR 4.3
ReproSalud teams have up-to-date information on women's expressed demands

## 2.2 Description

The Results Framework is an attempt to link conceptually the different aspects of the project to ensure better reproductive health outcomes among women.

The strategic objective of the ReproSalud project is to *"Increase utilization of reproductive health resources and interventions by women."* The project aims to increase the use of preventive self-care and other innovative approaches to reproductive health, in addition to increasing use of clinic-based services. Resources allocated and interventions initiated by ReproSalud refer to reproductive health care actions that are responsive and appropriate to the priority needs of women in rural and periurban areas.

The Intermediate Results described below are expected outcomes of project activities that contribute most directly to the achievement of the strategic objective. The four primary results are based on three hypotheses proposed by the USAID/Peru Office of Health and Population and the ReproSalud staff members (Brems et al., 1997): (1) women who experience ReproSalud's programmatic sequence[2] will make greater use of reproductive health services than they did before; (2) women who experience the programmatic sequence and participate in the project's economic activities (i.e., income generation or village banking) will make greater use of reproductive health services than women who experience only the programmatic sequence; and (3) women who participate in ReproSalud, either through the programmatic sequence alone or in combination with income-generating activities, will achieve more equitable gender relations with their partners, within their extended families, and in the community. The monitoring and evaluation plan for the project establishes the criteria and methodologies for testing these hypotheses.

## 2.3 Intermediate Results

Each of the four Intermediate Results in the ReproSalud framework describes one of the conditions critical to achieving the strategic objective. As an aggregate, they delineate changes in women's individual and group experiences within their households and community organizations, and with regional authorities and institutions. Also included are several basic principles that shape the implementation strategies of the project.

**IR 1. More equitable gender relations between women and women's groups and their partners, families, and communities.** The first Intermediate Result documents the changes in women's relations with men in diverse social contexts. A key tenet of the project is that women must identify and address key constraints in their lives to meet their own needs, develop their own

[2] Programmatic sequence refers to participation through a community-based organization in the competition for support under ReproSalud's *autodiagnóstico* activities, subproject design process, and the implementation of subprojects in reproductive health.

interests, and achieve their aspirations. Four subresults support progressive changes in gender relations:

IR 1.1. "Increased knowledge and communication on gender issues" addresses women's awareness of how gender issues affect their ability to advocate effectively for their reproductive health interests and to communicate their needs and desires to their partners and other key decision makers. The project supports activities that strengthen women's capacity to collect and analyze information about their relations with other household and community members and to communicate more effectively with their partners and community health authorities about their needs and aspirations.

IR 1.2. "Strengthened agency[3] of women to effect changes in gender relations" results from one of the guiding principles of the project: that through community-based organizations women will join in collective actions toward common goals.

IR 1.3. "Improved attitudes and practices of men in their relationships with women" is the result of project activities that involve men in a process of reflection and analysis regarding how women's experiences differ from their own and what actions men can take as individuals and as a group to redress gender inequalities. This result was not explicitly included in the original project design. Movimiento Manuela Ramos (MMR) added it at the request of some women who argued that activities aimed at changing their partners' behavior were key to the success of interventions aspiring to effect changes in their own lives.

IR 1.4. "Increased participation of women in identifying and managing activities based on their own priorities" is a key result of the programmatic sequence. The project's participatory methodology involves women in a series of implementation processes that are designed to develop their capacity to plan and conduct reproductive health and income-generating programs in their communities, and to improve their ability to advocate for support services.

**IR 2. Increased proportion of household income and resources allocated for women's reproductive health care** is the outcome of project activities that aim to give women increased income and control over their resources. The rationale for supporting income-generating activities through the project is that, by attaining greater access to and control over household resources, women will be in a better position to negotiate and direct household expenditures to benefit themselves as well as other household members. The logic of this argument, and the following subresults, presupposes that women value their own reproductive health, as do other key decision makers in their households:

IR 2.1. This subresult posits a normative change of "Increased value ascribed to women's health within rural and periurban households and communities."

[3] Agency as used here implies that, working collectively, women are able to become actors in their own right by being the authors of their own actions.

IR 2.2. “Increased capacity of women to influence decisions about household expenditures according to their priorities” represents the effect of the project's impact on women's abilities to articulate and negotiate the allocation of household resources to their needs.

IR 2.3. “Increased access to sources of income, credit, and markets” is the anticipated result of the project's income generation and microcredit interventions.

**IR 3. Increased capacity of women to access services and influence improvements in their quality** is the result of the different activities aimed at augmenting women's knowledge and awareness about the prevention of reproductive health problems, their options for self-care and other health and family planning services, and their capacity as individuals and group members to advocate for appropriate responses to their reproductive health care needs. As is the case with IR 2, IR 3 subresults will be achieved only if there is an increased recognition of the importance of women's health. In the past, when health services have been unresponsive to women’s needs, the vast majority of rural women have opted not to use those services. The subresults under IR 3 (listed below) aim to change that dynamic by helping individual women to know what to expect and demand as quality care, and to develop organizations that can negotiate, mediate, and monitor the quality of services on their behalf:

IR 3.1. “Increased value ascribed to women's health in rural and periurban households and communities.”

IR 3.2. Women will be “more informed, effective, and assertive clients of reproductive health services.”

IR 3.3. “Community-based organizations that represent women in their communities and negotiate with local and regional health authorities on their behalf” will be strengthened.

**IR 4. Community-based organizations, Movimiento Manuela Ramos, Regional Coordinating Committees (RCCs), nongovernmental organizations (NGOs), and other social actors participate in a process to formulate and adapt reproductive health norms and programs to the localities and regions where ReproSalud is active.** Results at this level will be the product of national-level advocacy activities. Through these efforts, the MMR strives to influence national reproductive health policies and norms and to persuade the Ministry of Health (MOH) to incorporate the perspectives of poor women into reproductive health care in rural and periurban areas of Peru. The advocacy component has the explicit objective of building linkages to other service delivery interventions. It is through advocacy activities that women participating in the project voice their needs and champion socially and culturally acceptable health services. The advocacy component helps women focus on changes outside their immediate social milieu and on how to make those changes coincide with their needs as they perceive them. Achievement of IR 4 is contingent on the following:

IR 4.1. “Local authorities being sensitized to make changes that incorporate women’s perspectives.”

IR 4.2. “Active promotion of women’s reproductive rights by civil society groups.”

IR 4.3. “ReproSalud’s regional staff keeping up-to-date information on women’s expressed demands.”

***Recommendation.*** This Results Framework should be considered as preliminary. Although we have worked on revising the objectives with the ReproSalud staff, the framework requires additional fine-tuning, which the project staff is best suited to accomplish. We have also provided suggestions for indicators that reflect each of the main Intermediate Results. These indicators appear in Appendix D.

The next step in developing the overall evaluation plan will be to elaborate a plan for each Intermediate Result as illustrated in the matrix presented in Table 1. Each of the factors specified should be considered.

**Table 1**

**Factors to Be Specified in Elaborating a Monitoring and Evaluation Plan**

| Objective | Indicators | Targets | Baseline Value | Reporting Periods | Data Source | Timing of Data Collection | Person Responsible[a] | Cost |
|---|---|---|---|---|---|---|---|---|
| Strategic | | | | | | | | |
| IR 1 | | | | | | | | |
| IR 1.1 | | | | | | | | |
| IR 1.2 | | | | | | | | |
| IR 1.3 | | | | | | | | |
| IR 1.4 | | | | | | | | |

[a] Person responsible for all aspects of the data collection and analysis.

# 3. STRATEGIES FOR EVALUATING WOMEN'S EMPOWERMENT AND REPRODUCTIVE HEALTH

Many of the processes of interest in this project have to do with redressing gender-based inequities and addressing strategic gender needs. Social inequalities based on class and ethnicity, however, also negatively affect reproductive health. We believe that women's empowerment is a useful concept for understanding the ReproSalud project and tracking its impact because the concept is sufficiently broad. Through the project interventions, women may become empowered to overcome barriers imposed by a variety of forms of social inequality, including those based on gender. A basic feature of the ReproSalud project is its use of empowering interventions. Participation in project activities is, in itself, intended to be an empowering experience for women. The interventions are also intended to function as catalysts to bring about more far-reaching and enduring forms of women's empowerment, and this empowerment is expected to have a positive impact on reproductive health.

We identify four basic tasks in evaluating the effects of the ReproSalud project on women's empowerment and reproductive health, as shown in Figure 2:

1. Describe the existing situation, against which the project impact is to be measured.
   a. Construct an "ethnographic baseline," using the information that emerges from the *autodiagnóstico* and subproject development to describe the ways in which women in the project communities are disempowered, and how this disempowerment hampers reproductive health. Organize this material in terms of "indicators of empowerment and disempowerment" that can be reassessed later, either through qualitative research or structured surveys.
   b. Finalize design of and carry out the structured baseline survey for statistical analyses of impact.

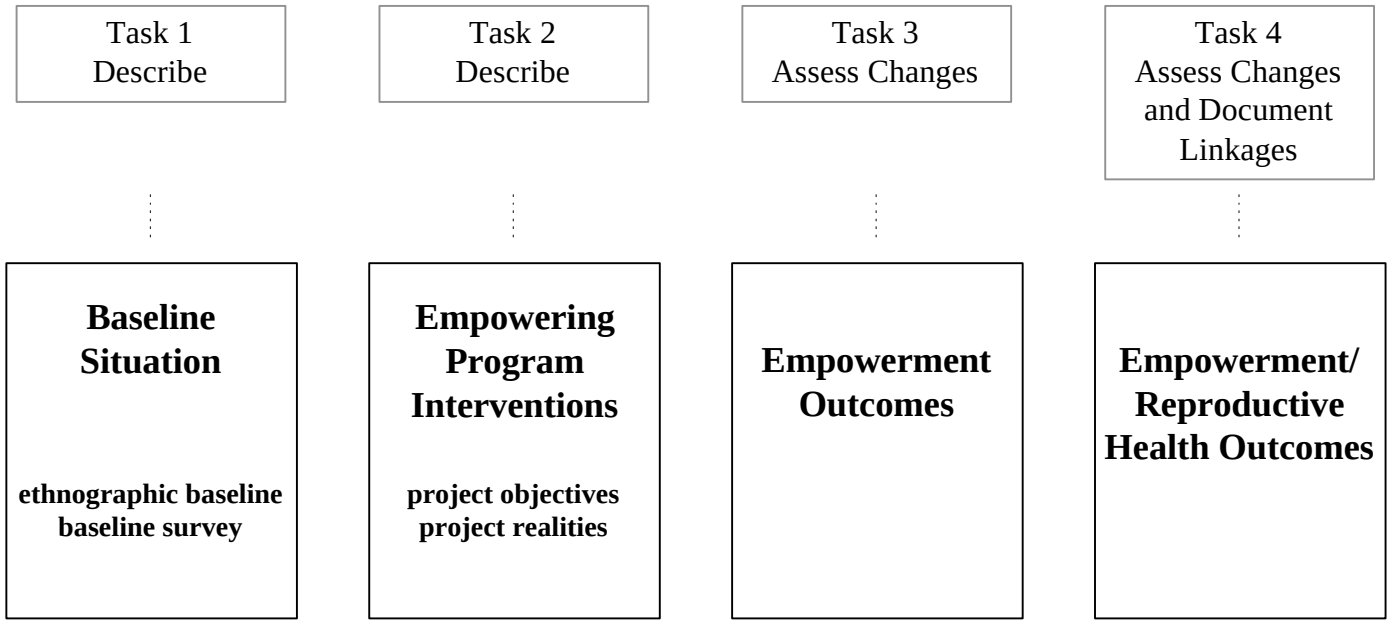
2. Describe the ReproSalud interventions in detail, contrasting the objectives and ideal model of the project with "on the ground" realities. Provide evidence from the perspectives of participants to show how the *autodiagnóstico* and other project activities are empowering for women.

3. Assess changes with respect to the empowerment indicators, both through qualitative research and through follow-up surveys.

4. Assess changes and document linkages between the empowerment indicators and the indicators related to reproductive health, both through qualitative research and through follow-up surveys.

**Figure 2**

**Evaluating the Effects of ReproSalud on Women's Empowerment and Reproductive Health**



Women's empowerment can take many forms, and the specific ways in which the ReproSalud project can potentially empower women are also many. The project has an open-ended design. The project creates mechanisms so that specific empowerment and reproductive health interventions can evolve from identified needs, and can build on new capacities and interests that develop in participating communities. An evaluation plan is needed that is open-ended enough to document unforeseen outcomes. At the same time, it is important to remember that a comprehensive study of women's empowerment in Peru would go beyond the scope of project evaluation research. While maintaining a certain amount of flexibility, the evaluation must focus on a manageably small set of empowerment outcomes that are (1) likely to occur within the time frame in which they are being assessed, (2) feasible to assess, and (3) clearly related to the project's Results Framework. In addition, empowerment indicators to be included in the structured survey and used in statistical analyses should be relevant across project sites.

Empowerment indicators, or sets of indicators, will be assessed through three different mechanisms: project monitoring, qualitative studies, and structured surveys.

***Project monitoring.*** Building on what is already being done, simple monitoring procedures should be established to capture important project outcomes that may be relatively infrequent in the initial years of the project and may be unpredictable as to where and when they will occur—for example, advocacy activities undertaken by CBOs or by coalitions of CBOs. If monitoring systems are established so that CBOs or MMR staff members record such events, researchers can later visit the relevant sites to document these important events in more depth and to explore their potential impact on health services and within communities.

***Qualitative studies.*** Ethnographic case studies can be undertaken in selected communities to document the processes and outcomes of the project in depth. Such studies can provide considerable insight into the project implementation process. They can be used to analyze who within a community or group of communities is reached, who is not, and why. They can also provide descriptive data to illustrate how ReproSalud empowers individual women and groups to take action, and how families, communities, and reproductive health service providers are influenced.

***Structured surveys.*** Baseline and follow-up surveys are being designed to provide data for statistical analyses of impact. These surveys will, ideally, include a small set of relatively unambiguous indicators of women's empowerment, as well as (1) sociodemographic variables, (2) indicators to show the extent of each respondent's participation in the ReproSalud project (see Appendix E), and (3) variables related to reproductive health.

## 3.1 Existing Sources of Data

The ReproSalud project has already generated a large amount of data. For the most part, this data collection was designed to support project development, not evaluation. Nevertheless, much of it can be used in task 1 (constructing an ethnographic baseline) and task 2 (describing the project interventions as designed and implemented from the perspective of women's empowerment). Existing data sources are described in Appendix F. Except for the follow-up surveys, so far nothing has been planned to evaluate impact.

## 3.2 Describing ReproSalud's Empowerment Methodology

In the ReproSalud project, activities are developed around women's expressed priorities and through their participation in design and implementation. In this sense, the *autodiagnóstico,* the subproject design process, and the implementation of subprojects are all designed to be mechanisms for women's empowerment. Thus, one basic task in evaluating women's empowerment as a potential outcome of the ReproSalud project will be to describe these ReproSalud interventions in detail, contrasting the objectives and ideal model of the project with "on the ground" realities. Evidence should be assembled from the participants' perspectives to show whether, and how, the project activities are empowering for women.

For international audiences in particular, the open-endedness of the ReproSalud methodology may lead to misunderstanding about what is actually being done. For example, it will be important to highlight the fact that all of the subprojects in the initial years of the ReproSalud implementation project consist of community-level education. The process documentation could highlight the differences between ReproSalud and traditional information, education, and communication (IEC) approaches geared toward communicating public health messages to induce people to adopt particular behaviors. Traditional IEC approaches sometimes reinforce gender-based inequities rather than challenge them.

The advocacy component of the ReproSalud project has, so far, not been well documented because most of the documentation has focused on the *autodiagnóstico* sessions and the training subprojects. It will also be important to describe the advocacy activities that are being done simultaneously with the CBO selection, the *autodiagnóstico,* and the initial subprojects, and to explain how this approach is meant to lay the groundwork for more substantial attempts to pressure health services to become more responsive to the people they are meant to serve.

Documentation of the challenges faced in implementing ReproSalud's empowerment methodology will be important for replication purposes. For example, according to project documents and guides, the ReproSalud interventions are to be implemented using a nondirective and participatory methodology. In many cases, however, both the participants and the regional promoters are accustomed to hierarchical relations and welfare styles of interaction. It is difficult to shed modes of social interaction that are deeply ingrained. Hierarchy is built into the Peruvian

educational system and the training methodologies that the promoters and the participants have been exposed to previously.

Project documents, particularly the implementation guides, and Anna Britt Coe's study (forthcoming) can be used to develop a description of the ideal model of ReproSalud's interventions as designed. There are numerous existing sources of data that can be used to develop a description of the project as it is being implemented: Maria Rosa Garate and Carmen Yon's comprehensive *autodiagnóstico* reports, the documentation of Yon's current work on improving the implementation and documentation of *autodiagnóstico,* reports of the *autodiagnóstico* and subproject design process provided by regional teams, reports of the *nulceo responsible* on the subproject, subproject evaluation reports, and results from the Coe study.

### 3.3 Constructing an Ethnographic Baseline

We have coined the term "ethnographic baseline" to highlight the need to describe in a systematic way women's situations in the project areas at the start of the project. This information cannot be statistically representative. It can, however, serve as a baseline against which changes can be described qualitatively. We suggest that the qualitative baseline contain two types of information: (1) a general ethnographic description of women's situations in the different types of sites where ReproSalud works (rural Andean highlands, rural jungle, and periurban Lima), focusing on issues related to gender, empowerment, and reproductive health; and (2) specific information pertaining to a sample of communities, households, and individual women.

1. General ethnographic descriptions of women's situations in project areas will provide the following:
   - Contexts within which to describe the project's empowerment strategies;
   - A framework for identifying relevant aspects of empowerment that can be explored through focused, qualitative studies; and
   - A conceptual starting point for designing quick, retrospective data collection to further document impacts that are identified through project monitoring.

One of the early accomplishments of the ReproSalud project has been the generation of in-depth information about the life experiences and social conditions of disadvantaged women in rural and periurban areas of Peru. Such information, gathered from the perspectives of the women themselves, has rarely been sought, let alone acquired, by social programs in Peru. In ReproSalud, it has been generated mainly from the *autodiagnóstico* processes. For example, participants in the *autodiagnóstico* have identified specific issues reflecting disempowerment and gender inequality that affect their relationships with their male partners and their families. These issues include inadequate awareness of and communication regarding reproductive health and human rights, low priority given to women's health and other needs, women's weak position in negotiating contraceptive use, coercion in sexual relations, infidelity, domestic violence, and constraints to women's social participation. Five complementary studies, as mentioned, will examine in greater

depth issues identified by participants, and the Coe study will provide additional data. It should be possible, therefore, to construct an ethnographic baseline using information that already exists, and from the qualitative studies that have already been designed. This documentation can be used to analyze how women in the project sites are disempowered. (To some extent this documentation has already been done in the thematic extractions from the *autodiagnósticos*—specifically, those on gender issues, health services, and domestic violence—and in Anna Britt Coe's research.)

2. Specific information pertaining to a small sample of communities, households, and women (who would then be followed over time through repeated visits) can be contrasted with the follow-up data. The information can be presented in the form of case studies, showing how involvement in the ReproSalud project can affect individuals, families, women's groups, communities, and, possibly, local officials and health service providers.

Because of time constraints, the POPTECH Team was unable to assess whether the existing data from the *autodiagnóstico* could be used in developing ethnographic baseline profiles for a sample of specific communities, but we understand that this task is now being done by ReproSalud. We also suggest that the complementary studies be used to compile such information for small, nonrandom samples of communities, households, women, and CBOs, which could be followed over time.

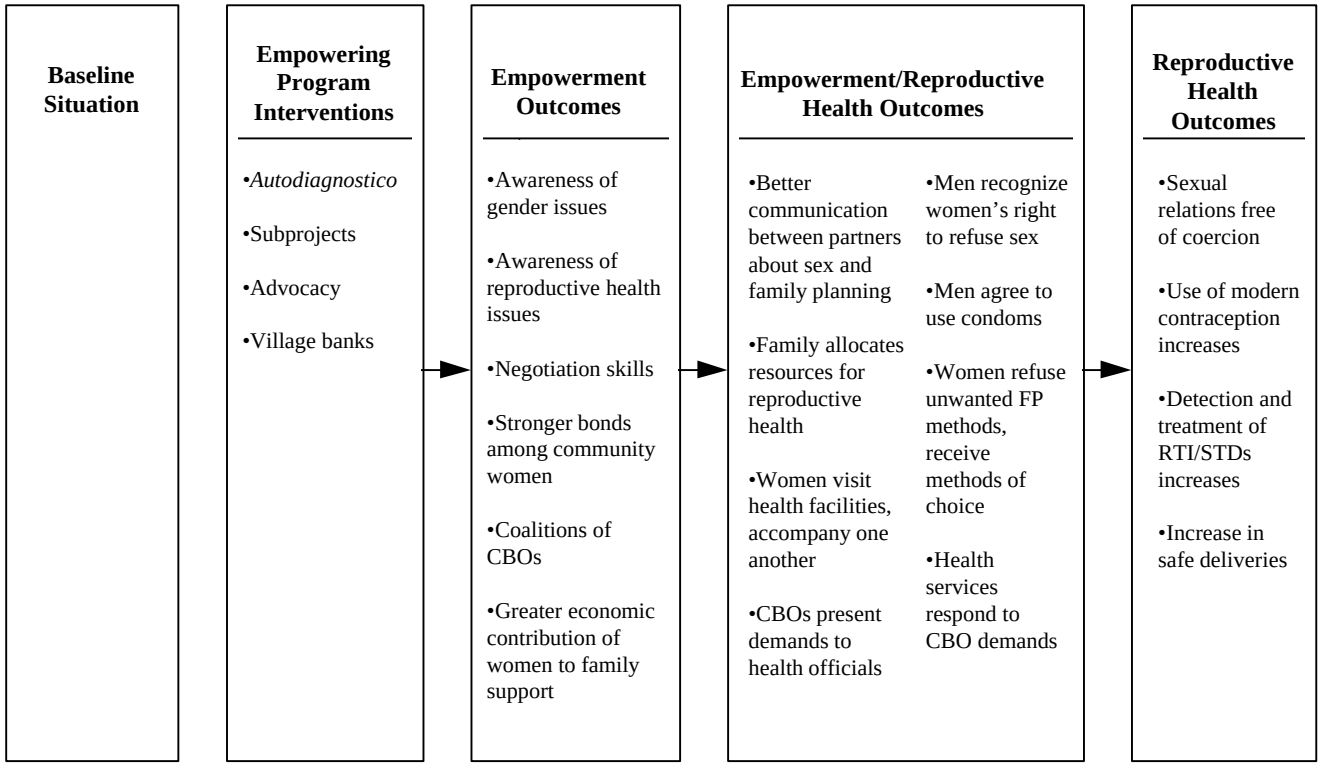
### 3.4 Developing Indicators of Women's Empowerment

The ReproSalud project is intended to stimulate empowerment processes at various levels: in the individual psyche; within the family; and within women's groups and communities, as well as beyond the community and in relationships with health services and policy makers. The intended effects on reproductive health are expected to occur as a result of these empowerment processes, which may not evolve in the same way, in the same sequence, or at the same pace in all project sites. Ethnographic case study approaches and monitoring procedures can be used to document empowerment outcomes that are not anticipated. It will also be important to design research studies in relation to some specific empowerment outcomes that are expected to occur and to influence reproductive health.

Figure 3 shows how empowerment outcomes that might be expected to occur can be organized in the process of developing evaluation indicators and research approaches. The distinction between the empowerment outcomes in box 3 and those in box 4 is that those in box 3 may or may not influence behaviors that promote reproductive health. The outcomes in box 4 are manifestations of empowerment that fall within the sphere of reproductive health, but may or may not translate into improved health status because other necessary conditions for such improvement may be absent.

**Figure 3**

## Examples of Program Outcomes



Some of these outcomes are already stated in specific enough terms to be treated as indicators, at least in qualitative studies; others would have to be specified in more detail to serve as indicators. For example, the formation of "coalitions of community-based organizations" in project areas (box 3) could be considered an empowerment indicator. "Awareness of gender issues" would have to be further specified (e.g., in terms of women's perceptions about division of labor in the household, or their right to refuse sex). "CBOs present demands to health officials," and "health services respond to CBO demands" (box 4) would be indicators of empowerment that are directly related to reproductive health. "Men agree to use condoms" would be another such indicator. "Family allocates resources for reproductive health" would need to be further specified.

The outcomes (and implied indicators) in Figure 3 are meant to be illustrative. The final set to be assessed through the evaluation research should be determined by the ReproSalud project team, taking into account what has been learned from the implementation process so far, and from the construction of the ethnographic baseline, keeping in mind the criteria suggested earlier:

- Likely to occur within the time frame in which they are being assessed,
- Feasible to assess, and
- Clearly related to the project's Results Framework.

(In addition, empowerment indicators to be included in the structured survey and used in statistical analyses should be relevant across project sites.)

The ethnographic baseline can be used as a source of empowerment indicators in that it will describe how women are disempowered—for each form of disempowerment, empowerment would be the opposite situation, or the overcoming of the constraint. Another potential source of empowerment indicators is the "What is a happy woman" exercise that is part of the *autodiagnóstico*, in which women visualize how they would like their lives to be. In attempting to extract empowerment indicators from these exercises, however, it will be important to analyze the women's statements, not merely to accept them at face value. (For example, a woman oppressed by domestic violence might articulate the need to improve herself to avoid provoking violence in her husband, whereas from our perspective the solution probably would lie in a more egalitarian relationship. The woman may be acutely aware of the problem of violence in her life, but unable to visualize a viable alternative.)

Once we have identified a set of key empowerment outcomes and indicators, either using a diagram similar to that in Figure 3 or the project's Results Framework, the next steps would be to (1) determine which indicators should be tracked through monitoring versus qualitative research, structured surveys, or a combination of methods; and (2) develop monitoring mechanisms, study protocols, and data collection instruments accordingly.

## 3.5 Recommendations for Qualitative Assessment of Empowerment Outcomes

Following are a few recommendations to consider in elaborating qualitative studies and monitoring procedures as well as data collection instruments to assess ReproSalud's impact on women's empowerment and reproductive health.

***Recommendation: Repeat the complementary studies.*** The five complementary studies could be repeated (1) after a period of time has elapsed, (2) by the same investigators, (3) in the same sites chosen for the initial research, (4) using similar methods, and (5) adding additional questions to investigate possible program effects on the specific problems uncovered in these studies. Ideally, the initial and follow-up studies should be in ReproSalud sites, as well as in a few comparison sites.

***Recommendation: Repeat the autodiagnósticos.*** A follow-up *autodiagnóstico* could be conducted with the original participants in a sample of sites where the initial *autodiagnóstico* was well documented and analyzed. This follow-up could show how the participants' abilities to articulate and address problems has changed. Repeating exercises such as "What is a happy woman?" could show whether the project has influenced women's gender identities. A separate *autodiagnóstico* with participants who were not involved in the initial one might provide evidence as to whether the project has had much impact in the larger community. These data could be used in qualitative descriptions, even if there are variations among sites in the way the *autodiagnóstico* is conducted. As much as possible, however, the follow-up *autodiagnóstico* in a given site (if it is being done for evaluation purposes) should be conducted by the same field staff using the same methodology that was previously used in that site. Although a high degree of standardization may not be appropriate or feasible, every effort should be made to document variations in the *autodiagnóstico* process in (and among) sites where it is being used as a research tool, so that these variations can be taken into account in interpreting the data.

***Recommendation: Set up a monitoring system to track important project outcomes such as grassroots advocacy initiatives and increased use of reproductive health services.*** Advocacy by community groups to improve health services is one of the most important empowerment outcomes anticipated in this project. Relevant information could be collected from the ReproSalud field staff in all sites and from key informants in a sample of project sites. Events recorded through monitoring systems can be verified and documented in greater depth, retrospectively, by researchers.

When small retrospective studies are designed to investigate outcomes that have been identified through monitoring, the information about typical forms of disempowerment (based on analyses of the *autodiagnóstico* and complementary studies) can provide a focus for interviews that would explore how empowerment is taking place. In this sense, the information can be treated as a "conceptual starting point" in structuring the follow-up research, as well as in presenting the findings.

***Recommendation: Develop questions and interview techniques to get beyond ideology.*** The participatory methodologies used by ReproSalud in the *autodiagnóstico* and the training subprojects are designed to get women to reflect, think, and talk about themselves in ways they normally would not. Women are encouraged to talk about their experiences and about gender roles and relationships in terms of human rights. For example, they may discuss the widespread idea that husbands have the right to sex on demand, and they may decide that this demand is unjust and not conducive to reproductive health. The project is also giving women clearer ideas about reproductive health services that they should, ideally, have access to in health facilities. ReproSalud's experience so far suggests that there are many instances in which the project is succeeding in raising women's awareness in relation to issues of gender and women's rights.

The ability to reflect and talk about gender roles and human rights may be a necessary first step for change, but it is only that. Similarly, the idea that women can avoid or manage serious health problems by getting regular Pap smears does not mean that women will succeed in getting Pap tests with reliable lab analyses. In a recent qualitative study (Coe, forthcoming), for example, a ReproSalud participant stated that women in her community now had fewer problems with vaginal infections because they got regular checkups and Pap smears and because they were no longer allowing their husbands to force them to have sex after having relations with other women. Obviously, the incidence of vaginal infections could not have changed so quickly, and it is doubtful that the women's relationships with their partners and with reproductive health services has been transformed as rapidly and radically as this statement might imply if taken at face value. From an evaluation perspective, it will be important not to confuse women's ability to talk about rights and health-promoting behaviors with their ability to exercise their rights and to get support from partners and health providers to promote reproductive health. In-depth case studies will be needed to understand the relationships between attitudinal statements phrased in terms of actual behavior and actual behavior.

***Recommendation: In designing questions about behavior, make them as concrete and specific as possible.*** Questions phrased in abstract or hypothetical terms (e.g., "Who controls the decisions in your family?") often elicit normative responses or statements intended to please the interviewer.

***Recommendation: Use a combination of methods to assess quality of care from client perspectives.*** Schuler and colleagues (1998) found that a combination of methods—direct observation of client-provider interactions and interviews done in the community with women who have recently used the health services—was very effective for eliciting client perspectives of service quality. The direct observations were useful both for designing interview questions and for interpreting what the women said. The "mystery client" methodology (Huntington and Schuler, 1993; Schuler et al., 1985) may also be useful for this purpose.

### 3.6 Indicators of Women's Empowerment for Use in Statistical Analyses

In recent years, there has been a growing interest in developing indicators of women's empowerment that can be used cross-culturally in structured surveys such as the DHS. We view this effort with some skepticism. Although it may be possible to identify aspects of women's empowerment that are relevant in a wide range of societies, these aspects of empowerment will have very different meanings in heterogeneous social settings. Suggestions for empowerment indicators and survey questions that are based on experience from other countries may be useful as sources of ideas, but they should be adopted only if they are clearly meaningful in relation to reproductive health in Peru, across ReproSalud's heterogeneous sites.

The difficulty of measuring women's empowerment through structured surveys should also be weighed in selecting indicators. Questions worded in a general way (e.g., "Who in the family decides/controls...") often generate normative responses rather than statements about actual behavior. And issues such as control over resources and decisions are typically too complicated to be captured in one or two questions. Experience suggests that many aspects of empowerment are best assessed through qualitative research.

***Recommendation: Be judicious in selecting empowerment indicators for statistical analyses.*** We suggest that the ReproSalud baseline and follow-up surveys use a small set of items that are related to women's empowerment, that are clearly linked to the project's Results Framework, and that are likely to be meaningful across sites. (Empowerment can be looked at more broadly through qualitative research.) The baseline survey contains an assortment of questions that can be used as indicators of women's empowerment in various spheres of life, some directly connected with reproductive health. It also contains questions that probably should be dropped because they are too general, ambiguous, or difficult to answer. The baseline survey is also very long, so, in the interest of brevity too, it would probably be a good idea to drop some of the questions.

We suggest that the following list of topics be used in statistical analyses of the relationships between women's participation in ReproSalud and their empowerment and reproductive health. With one exception, all of these topics are already covered in the baseline survey. (The letter "Q," followed by a number indicates the related baseline survey question.)

1. Woman's relative cash contribution to family support (proportion of household expenditures met through her income)

2. Participation in organizations (Q. 401, 401a)

3. Attitudes toward and subjection to domestic violence (Q. 256, 257, 258)

4. Husband's participation in child care (Q. 417)

5. Attitude regarding the husband's right to sex on demand (Q. 212b, 261, 406)

6. Discussion of family planning with husband, children, and others (Q. 221, 222, 226, 506)

7. Attitude regarding women's use of contraception without her partner's agreement (Q. 219)

8. Partner's cooperation in family planning (Q. 212a)

We suggest that these eight topics be treated individually in statistical analyses and not combined into a scale, unless a clear rationale for combining a subset of indicators emerges during the analysis. However, like items could be used to construct a scale (e.g., those listed in item 5) if such a scale seems to make sense based on the distribution of responses for each item. Maintaining the eight separate topics will make it easier to relate the statistical with the qualitative findings and to trace the steps through which the project interventions empower women and affect reproductive health (because it will be relatively clear what is being measured). It will help to avoid "mystification" in presenting and interpreting the findings. An additional rationale for using a variety of distinct empowerment indicators is suggested by the findings of Schuler and colleagues. The duration of women's involvement in microcredit programs was found to have a statistically significant impact on several aspects of empowerment. A separate but overlapping set of empowerment indicators had significant effects on contraceptive use (Hashemi et al., 1996; Schuler et al., 1997).

It will be very important to do additional qualitative research to describe the social processes around these topics in more detail to confirm that the indicators of empowerment used in the statistical analyses are meaningful and valid, and to describe their limitations.

***Recommendation: Eliminate ambiguous or nonessential questions.*** We suggest eliminating questions that are potentially ambiguous and those that probably will not be useful for evaluating the impact of ReproSalud on women's empowerment and reproductive health. For example, we would eliminate most of the section on income generation and, instead, do in-depth case studies in selected sites where ReproSalud has established village banks or microenterprise interventions. Experience elsewhere suggests that a much longer series of questions would be needed to accurately measure income in the rural and periurban settings where ReproSalud operates. Improvements in income as a result of the ReproSalud project village bank and microenterprise interventions will probably take a relatively long time to occur. Even if measurable improvements do occur, it will be extremely difficult to attribute them to the ReproSalud interventions and to statistically measure the effects on women's empowerment and reproductive health. One or two indicators of household economic status however, should be retained to be used as control variables.

As an alternative, we suggest including a very short series of questions to determine what (cash) income-earning activities the (female) respondent is engaged in and a rough indication of the proportion of household expenses that are met with income earned by her, according to her and according to her husband (e.g., a negligible share; a substantial proportion, but less than half; about half; most or all). A similar indicator was found to be highly correlated with participation in

microcredit programs, indicators of women's empowerment, and use of contraception in a study in Bangladesh (Schuler and Hashemi, 1994; Hashemi et al., 1996; Schuler et al., 1997).

Because they are too general, we recommend eliminating most of the questions on women's participation in decision making and control over income. Given the wide range of cultural, ecological, and economic variation in the ReproSalud project areas, it would be very difficult to devise a set of concrete, specific questions that would be adequate for measuring these aspects of women's empowerment across sites. Site-specific, qualitative research will probably be more useful for this purpose.

Furthermore, we suggest eliminating the questions on division of labor by gender, because these questions may generate normative responses and because it is not clear how this information could be used to measure impact on empowerment and reproductive health. Descriptions of division of labor in project communities, if needed, could be done more effectively and efficiently through observation and key informant interviews. The questions regarding the husband's role in caring for children could be retained as indicators of women's empowerment.

***Recommendation: Use carefully selected hypothetical questions.*** Hypothetical and general questions can sometimes be useful for assessing impact, as long as they are clearly described as such when the data are analyzed and presented. For example, women participating in ReproSalud may be more likely than nonparticipants to state in the survey that a man does not have the right to demand sex when the woman is unwilling (a topic that is likely to have been discussed in the *autodiagnóstico* or an educational subproject). Such a statement may indicate a new awareness regarding the inequity of the traditional norm (men's right to sex on demand). Women may even say that both they and their partners decide when to have sex, in response to the nonhypothetical version of this question in the baseline survey. Such responses should be treated with caution. Given the complexity of dynamics around sexuality and control, in-depth research would be needed to understand whether and how this decision really happens.

***Recommendation: Selecting reproductive health indicators to show impact.*** We suggest that, in general, reproductive health indicators should focus on individual knowledge, attitudes, and health-seeking behaviors; group activities to improve health; and individual and group interactions with health services and policy makers, rather than on health impacts that are difficult to measure in small populations and on outcomes for which a long period of time may be required to detect significant changes. As mentioned, the baseline survey instrument already contains a number of items along these lines. The monitoring data and special studies can provide additional evidence of change in these indicators. Additional indicators are suggested in Figure 3.

# 4. INDICATORS AND EVALUATION ISSUES FOR MICROENTERPRISE AND CREDIT

## 4.1 Evaluation Issues Regarding Microenterprises and Women's Banks

***Background.*** There is widespread consensus that a relationship exists between a woman's increased access to and control over economic resources and the improved education and nutrition of her children. There is also general agreement that women's decision-making ability within the household is increased as her income increases (usually with the caveat that her income increases in proportion to her partner's income). What is yet untested is whether increasing women's income in conjunction with a health program designed to heighten women's awareness and capacity to act upon their knowledge of reproductive health can result in improved health status for women. ReproSalud's income-generating component provides an ideal opportunity to explore this relationship. This program consists of two distinct components that are compatible but are not necessarily implemented together. One is credit activity, and the other is product development.

The vehicle ReproSalud has used to date to provide credit to women is the village bank model. Groups of approximately 20 women with income-generating potential are organized into a village banking group. The village bank follows very strict operating guidelines. The guidelines specify the administrative structure, include repayment schedules, and require monthly savings in addition to the loan repayment. The banks are organized around a projected series of six loan cycles, each of four months, for amounts between US $200 and US $300. Nine village banks with an average of 22 members each are currently in operation.

The product development component seeks out marketable products, most of which will allow women to work in their own homes, and links that production to markets. The more common products currently under consideration are modifications of products women can and do produce in their homes.

ReproSalud is working in eight different geographic areas, with the microenterprise and microcredit component operating on a pilot basis in four. After the pilot phase, ReproSalud has decided to limit its microcredit activities to one or two regions. In Pucallpa, a semiurban area in the Amazon basin region, for example, the response to village banks and the interest in product development has spread quickly and far exceeds expectations. Accordingly, there would be ample opportunity to conduct small-scale studies comparing separate communities in the same region for the impact of these different combinations of activities on women's reproductive health practices. Some communities would have experienced only ReproSalud's direct reproductive health interventions; others would have experienced the health interventions combined with the credit or the product development component, or both. These studies could be included within other targeted studies. For example, a panel study investigating changes in women's empowerment over time could include women who had or had not participated in microcredit or income-generation

projects. Possibilities for a panel study within the baseline survey are discussed in Section V of the questionnaire. We have identified the outcome indicators included in the current baseline survey and turn to them next. In general, the Team believes that many of the items included in Section III (Income Generation) of the questionnaire and some of the questions in Section V (Use of Health Services and Expenditures in Health) are potentially ambiguous and would be more useful for evaluation of the impact of ReproSalud on women's reproductive health if they were modified.[4]

When one considers the design of a study that looks at the effects of income generation on women's lives, it will be especially important to be aware of constraints. Therefore, the final section of this chapter considers issues that will limit the effects of income-generating activities and finance.

## 4.2 Specific Indicators for Microfinance and Credit in the Current Baseline Survey

A number of items in the baseline survey are intended to measure Intermediate Result 2 (IR 2) and its subresults. Intermediate Result 2 hypothesizes "increases in the proportion of household income and resources allocated for women's reproductive health." In general, the Team thought that many of the items included in Section III (Income Generation) and some of the questions in Section V (Use of Health Services and Expenditures in Health) of the questionnaire were potentially ambiguous and would not be useful for evaluating the impact of ReproSalud on women's reproductive health.

A process that contributes to this objective is IR 2.1: increased value ascribed to women's health in rural and periurban households and communities. Following are several questions that are included in the current questionnaire that could be used to examine hypotheses about IR 2.1. Better questions could and perhaps should be developed; however, since it is not clear that this will be done, these items have been identified. Having some way to measure household decision making and control of resources in the sample as a whole is critical. The possibility for variation by region, resource base, and ethnic group is great, and qualitative studies may not be able to provide information of this type across the sample. Quantitative data will provide an overview on regional and ethnic variations.

1. Monitor for associations between variables such as (a) the **degree of woman's involvement in ReproSalud activities** (see Appendix E for determination of this independent variable) and (b) the stated importance given to women's health from the following survey items:

[4] For example, questions 507 and 508 (listed as possible indicators for IR 2.1) that currently use a yes or no response scale should be replaced by a frequency scale for a greater range in statistical analysis. In addition, the response options to question 508 are not mutually exclusive (e.g., paid for a consult; medical history), nor do they permit a way of registering a repeated expense of the same type (e.g., respondent bought medicine five times last year).

- Do you believe that prenatal checkups are important, not too necessary, or unnecessary? (Q. 235)
- Did you have a checkup after you gave birth? (controlling for having given birth) (Q. 244)
- If not, why? (Certain responses such as "didn't think it necessary" and "not enough time" could be combined to test an inverse relationship with participation. Other responses ["treated badly," "difficult getting there"] are more likely to be related to perceptions of access to and quality of care, areas that are not included in the questionnaire but should be.) (Q. 245)
- Did you spend money on your **own** health in the past 12 months? (Q. 507)
- If yes, what was the expense for? (Q. 508)

2. Monitor for associations between variables such as (a) the **degree of man's participation in ReproSalud's activities** and (b) the stated importance of women's health, from the same select survey items listed above (see Appendix E for determination of this independent variable).

Intermediate Result 2.2 states that there will be "increased capacity of women to influence decisions about household expenditures according to their priorities" as a result of project participation. To examine this effect, one should do the following:

3. Monitor for associations between variables such as (a) the **degree of woman's access to empowering skills training** (see Appendix E on determining this variable) and (b) the ability to channel household resources, as reflected in select survey items[5] such as the following:
   - Who decides how the money you earn is spent? (controlling for access to income) (Q. 403)
   - Who decides how the household money is spent? (Q. 404a)
   - Given the household resources available, to what grade should your daughter study? To what grade should your son study? (controlling for children, male and female, under 12 years of age) (Q. 419)
   - Who decides the grade level your daughter should study to? Your son should study to? (Q. 420)

Additional items should be developed for IR 2.2.

Intermediate Result 2.3 postulates that women participating in microenterprise and credit activities will have "increased access ... to sources of income, credit, and markets." To examine this hypothesis, one should do the following:

[5] The team thinks that items 403 and 404a would benefit from additional refinement. However, we also believe that it will be important to examine questions like these to assess possible differences in patterns of decision making associated with ethnicity. This was found to be the case in the highlands of Ecuador (Alberti, 1986). Data from the baseline should be complemented with qualitative studies on decision making at the household level in different geographic and ethnic contexts.

4. Monitor for associations with variables such as (a) the **degree of woman's access to economic resources** that incorporate each of three components—sources of income generation, access to credit, and access to markets—and (b) the items used in IR 2.1 and IR 2.2 given previously. Where possible, compare strength of correlation when access to economic resources is taken alone, versus when participation is taken alone and when both are taken together. (See Appendix E on determining the degree of women's access to economic resources.)

### 4.3 Constraints to Studies of Income-Generating Activities

***Restrictive time frame.*** The time frame available to show the impact of women's involvement in income-generating activities on reproductive health and family planning practices may be too short. On the activity side, the CBO with the most advanced communal bank is just about to start its second cycle of a total of six loan cycles, and the product development activity has just been launched. For most of the other village banks, it may be close to a year before any marked change in income resulting from ReproSalud's income-generating activities could reasonably be expected to influence changes in women's reproductive health behavior.

On the demand side, there may not be enough women in a given group who are participating in the income-generating activities and who would require or be eligible for a reproductive health intervention so that a change in behavior could be detected. For example, suppose that a number of women in the group have just had babies, are pregnant, are going through menopause, or are single. It would be difficult in a year's time to say that intervals between births are becoming extended, or that modern methods of family planning are being more widely practiced. What it might be possible to detect, however, are changes in attitudes about modern methods of family planning or an increased discussion on the part of a couple about how many children they would like to raise, the use of prenatal and postnatal checkups for the mothers, and the variation in these indicators associated with income-generating activities.

***Recommendation.*** Given that changes in reproductive health tend to be detectable in the long term, while project feedback needs to occur in the short term, it may be necessary to use proxy indicators of changes in behavior rather than demonstrated changes, particularly where relatively small numbers of cases are available, such as in the income-generating activities (approximately 200 women working with nine banks).

***Absence of mutually exclusive options.*** The product development component focuses on products women can produce in their homes. The village banks are providing credit to women who are already engaged in some form of income generation, most likely either in the informal sector or as an extension of household tasks, such as raising chickens.

The dilemma arises from the fact that household-level, income-generating activities currently contemplated do not compel women to make choices between child care and earning an income.

Working at home or in the informal sector is generally not at odds with child care and is, therefore, less likely to have an impact on childbearing. Indeed, instead of providing an alternative to childbearing and child rearing, producing products at home is, in fact, complementary. By contrast, if a factory were to open in one of these areas, the possibility of factory employment would become an alternative that actively competes with child care and might prompt decisions about forestalling pregnancy.

Women who participate in the income-generating activities of ReproSalud should be learning financial and administrative skills as part of that process. To the extent that they are successful in their economic endeavors, their self-esteem should also be enhanced. As a consequence, these women should be better able to take a more active role in decisions at the household level, decisions on matters including, but not limited to, economic issues or reproductive health.

***Recommendation.*** Small-scale qualitative studies could examine whether and to what degree these women's participatory role in household decisions is changing according to the different combinations of ReproSalud activities.

***Increases in income not significant at the individual level.*** Let us assume that the income of women who participate in either the product development or the credit component of the income-generating activity increases 50 percent, or even 100 percent. From a project perspective, this increase would be a formidable accomplishment, but, from the perspective of an individual woman, what would such an increase in income mean? Would her income as a proportion of the total household income change that much? Although she would undoubtedly consider the increase in income to be significant, would it be enough to alter the balance of economic power between her and her male partner in the household? Would it lift her and her household from the category of extreme to relative poverty? These are just some of the questions that a small-scale qualitative study could begin to address. Data on income levels of women in marginal households from other countries suggest, however, that even doubling these women's incomes would not have a significant impact on their social relations in a wider context, although they might well have a qualitative impact on the education and nutrition of their children.

In addition to exploring the impact of increased microenterprise earnings ("increased" is an important word because many if not most of the women who will generate income from the products component of the project already earn money from some other informal source), it might be at least as important to trace the impact of the skills that the women learn in the process of the income-generating activities. These skills could include negotiating, conflict resolution, decision making, and financial and administrative skills.

***Recommendation.*** It is suggested that increased income is not enough for the income-generating component to be considered a success from a ReproSalud perspective. It may not even be a necessary outcome of the processes associated with income generation. Rather, the skills women learn while attempting to increase their income may be equally or more important. Qualitative studies could explore changes in aspects such as the incidence of domestic violence, the ability to

negotiate the time and place of sexual relations, their increased independence and mobility, and changes in the use of birth control, each in relation to the different combinations of ReproSalud components.

***Recommendation.*** It is recommended that ReproSalud reconsider the purpose of the income-generating component in its programmatic sequence. If the primary purpose is to improve women's reproductive health behaviors, then the process—and the skills learned in that process—may be far more important than the extent to which women's incomes are increased. If that is so, then the ReproSalud staff members may need to put greater emphasis on the specific skills that women need to learn to produce the smaller, more measurable-in-the-short-term, intermediate results leading to the desired long-term changes in their reproductive health behavior.

# 5. STRATEGIES FOR EVALUATING ADVOCACY AT THE LOCAL LEVEL

The objective of the advocacy component of ReproSalud is to promote women's rights and to advocate for programs and policies that respond to women's expressed needs and uphold their reproductive rights. It also aims to create links with diverse service delivery interventions. The advocacy component helps women identify what they want to change outside their immediate social milieu and how they can make those changes coincide with their needs as they perceive them.

ReproSalud seeks to develop women's advocacy skills through many project activities. The project advocates for women's rights and for changes in their gender relationships within their communities, regions, and country. At the district level, the project supports information sharing between women's groups, within communities, and with the regional authorities. The project supports CBO actions that advocate for greater attention and responsiveness on the part of health services to women's interests and expressed needs. Regional staff members also coordinate activities with health facilities and organize training sessions for women leaders in advocacy skills. At the regional level, advocacy activities include organization of and support for RCCs that bring together representatives of women's groups, NGO and MOH health providers, and local governments. MMR supports these local and regional activities with national publications on gender issues, public campaigns in support of women's reproductive and human rights, and participation on national committees to lobby for quality of care and client-centered reproductive health norms and protocols.

## 5.1 Advocacy-Related Activities Currently Being Conducted

***At the community level.*** The regional team conducts a situational analysis in each district where ReproSalud intends to work and then presents the project objectives to local officials and health professionals. Although these are not formally regarded as advocacy activities, they do lay the groundwork for subsequent CBO-based advocacy activities. The situational analysis documents the baseline conditions of health services against which any changes that result from the project's advocacy interventions can be measured.

Advocacy is incorporated within the subproject activities of the CBO. After completing the *autodiagnóstico* and subproject design, women from participating CBOs provide officials in the community and at the district level with information on the reproductive health problems they have prioritized, the subproject they have designed, and the activities they will carry out during the subproject. Some participating CBOs engage health post personnel directly in subprojects. For example, after the reproductive health training was held in Chavin, the community promoters held an interview with staff members of the health post and told them what they had learned and what they would like to see included or changed at the post (staff's treatment of patients was one area

identified). Subprojects specifically designed around advocacy have yet to be developed. Although the vast majority of initial subprojects are educational, CBOs are likely to design follow-on subprojects that advocate for specific changes in health care services.

***At the regional level***. ReproSalud's regional teams have organized RCCs that have been functioning since the project's inception. The committees include regional representatives from reproductive health and other organizations working in the region. Project 2000, Family Planning and Reproductive Health, NGOs working in health, and women's associations and federations (where they exist) are some examples. In the monthly or bimonthly meetings, ReproSalud's regional staff members inform committee members about the staff's activities in reproductive health with women in the CBOs. Once the subprojects are under way, representatives from the CBOs also attend the meetings of the RCC. They keep the committee abreast of what they are doing, and they present needs or demands when they have them. Some illustrative indicators suggested below will assist ReproSalud in tracking the maturation of the CBOs' advocacy activities with the RCC, from information sharing to joint decision making and lobbying for changes in service delivery and, possibly, in the allocation of local resources.

There are already many examples of how, through the RCCs, regional teams have forged relationships with regional officials to sensitize them to ReproSalud's objectives. Furthermore, the RCCs have coordinated activities and events for important women's commemorative days, such as March 8 (International Women's Day), May 25 (International Day for Women's Health), and November 25 (International Day Against Violence Against Women). It is significant that government institutions have become involved in the celebration of these events. In many regions, these dates were not even known by the public, let alone celebrated, before ReproSalud's advocacy efforts.

In general, the regional coordinators maintain good relations with local and regional officials. When members of ReproSalud's central office visit a region, the regional coordinator introduces them to MOH officials, district mayors, and in some cases church or other officials. At the same time, the regional team acts as a link between the counterpart CBOs and regional officials. For example, in Pucallpa last year for May 25th, the International Day for Women's Health, the regional team worked with the CBOs to develop a proposal for quality health services that the women then presented to the regional director of the MOH.

***At the national level.*** Through a number of different approaches, MMR advocates for national attention to women's reproductive rights and for services that are responsive to women's expressed needs. MMR collaborates with other women's and human rights organizations on public events that publicize the importance of women's rights, such as celebrations of International Women's Day, International Day Against Domestic Violence, and International Health Day, among others. They publish a quarterly bulletin on activities and accomplishments of ReproSalud, as well as monographs on specific topics relating to women's reproductive health and rights. They also sit on a national coordinating committee that lobbies the MOH to make national norms and protocols more gender sensitive and responsive to women's expressed needs.

The MOH and its regional and local representatives are the principal audience for MMR's national advocacy efforts.

## 5.2 Monitoring and Evaluating ReproSalud's Advocacy Component at the Local Level

ReproSalud is currently working with the Policy Project to develop indicators for measuring the impact of advocacy activities at the regional and national levels. Therefore, the indicators for measuring IR 4 and IRs 4.1–4.4 are not included in this report. Below are some suggestions on how the project can approach monitoring and evaluation of local-level advocacy activities.

The project encourages women to advocate for their needs early in the subproject cycle. Before choosing the CBO counterpart, the project establishes contact with local officials and health professionals. The regional team, through the RCC and other means, develops relationships with officials at the regional level, and then acts as a link between these individuals and the counterpart CBOs participating in ReproSalud.

Although ReproSalud is still in the process of developing an advocacy plan, documenting these activities and related outcomes in a systematic manner would benefit both program implementation and evaluation. It would be particularly useful to organize information about changes brought about by increased communication between CBOs and local political and health authorities. Informal conversations between the consultants and regional staff members revealed concrete results from advocacy activities, such as changes in clinic hours, community backing of women's demands, transportation provided by the mayor for women to attend International Women's Day activities, and interventions by local authorities to prevent domestic violence. Presently, documentation of this information is quite haphazard. It appears in subproject reports, regional team reports, and subproject evaluations.

***Recommendation.*** The project should develop a standard reporting system for capturing information on advocacy. Information should be compiled not only on the activity itself, but also on the purpose of the activity (e.g., maintaining public relations, presenting demands); the issue the activity is attempting to address; the group the activity is directed toward (e.g., health post personnel, local officials, school superintendents); the response of these targets; and whether the activity and targets are appropriate for addressing this issue.

Following are some suggestions for developing reporting mechanisms:

1. A roving researcher might visit as many different sites at the community level as possible to document what activities are being conducted with local authorities and health officials and what changes, if any, are taking place in terms of gender and reproductive health issues. This research could include interviews with local officials and health professionals, as well as with participating CBO members.

2. Each region could report and describe in detail an advocacy activity and its outcome as a standard inclusion in their monthly report.

3. ReproSalud staff members might be asked to routinely talk into a tape recorder on their rides home from other project activities to record any noteworthy incidents that they witnessed or heard about that occurred as a result of advocacy activities. This mechanism could be extended to include other noteworthy changes that came about in general as a result of project interventions. The tapes could be transcribed by the staff of the advocacy component in Lima so as not to overburden regional staff.

Although this information is, in and of itself, essential for demonstrating the advocacy efforts of the ReproSalud project, it can also be used to document changes that are expected to occur in part from such efforts. Specifically, the research would document changes in some of the dimensions of IR 1 and IR 3, such as in gender relations within the community and between women and local health services. (More equitable relations between women or women's groups and their partners, families, and communities [as the aim of IR 1], and increased capacity of women to access services and influence their quality [for IR 3].)

Changes could be documented by constructing a baseline that represents women's relationship with health services and gender relations in the overall community before ReproSalud's intervention and by using the following information: the Situational Analysis, the forms completed by CBOs that describe their prior activities, and the thematic extractions from the *autodiagnóstico* sessions on gender issues and women's perceptions of and relations with health services. The complementary studies being conducted at the present time on these two themes can also be used. Although the complementary studies are being conducted after the initiation of ReproSalud interventions, they focus on participants' perspectives on the problems in gender and in the health services, not on how these have changed since ReproSalud began.

Baseline information and specific indicators can be compared to information gathered through the monitoring system (as described) to document changes resulting from advocacy efforts that are related to IR 1 and IR 3. For instance, a CBO may identify hours of operation and a limited selection of contraceptives as problems in the local health post, and may lobby for change. Indicators of women's capacity to influence service quality would then include hours of operation that better accommodate women's schedules, as well as health personnel who describe a wider range of contraceptive options and who provide referrals to other services when they are not able

to supply the actual method choice. Another indicator relates to inclusion of women in community decision making. Women have indicated that men dominate at important community meetings. Related indicators that would document changes in gender relations in the community resulting from the project's advocacy efforts might include (1) greater attendance of women at community assemblies and (2) how active their participation is (for instance, do women express their opinions or inform the assembly of their activities?). Once a system of documenting anecdotal information like this is put in place, the relevant indicators will be obvious.

## 5.3 Advocacy Indicators

Broad-based participation in the CBOs is a critical factor in determining whether or not the advocacy activities are effective and whether they achieve outcomes that are representative of women's expressed needs. The monitoring of some key indicators that demonstrate the representativeness of CBOs and RCCs is a necessary precondition to monitoring the impact of advocacy activities. The following indicators are merely illustrative and suggestive of ways to monitor local advocacy activities.

**Indicators of representation within the CBO**

- Proportion of CBO members who have served in a leadership position
- Degree to which there is wide participation of CBO members in discussion (based on qualitative observations of facilitators and promoters)
- Proportion of members who state that their opinions and ideas are valued by the group

**Indicators of representation by the CBO of women in their communities**

- Number of CBOs that have established strategies to communicate with the wider community
- Proportion of women community members who support CBO proposals to community and regional authorities
- Documented examples of collective action by the community that results from CBO proposals
- Documented examples of support (resource, political, logistic) to CBOs by men and by other community organizations
- Proportion of women who are aware of the array of services offered at health posts and their hours of operation

**Indicators of effectiveness of the Regional Coordinating Committees**

- Number of regular meetings that are held and the number of meetings that are scheduled
- Proportion of meetings in which all participating organizations are represented
- Number of RCCs that have developed systems for channeling and monitoring CBO proposals for addressing women's needs
- Proportion of RCCs that have mechanisms for disseminating information and decisions
- Proportion of RCCs that are able to leverage resources and political support for proposals
- Number of proposals made by CBOs that are implemented and the number of proposals brought to the RCC by CBOs

Other indicators for regional- and national-level advocacy activities will be developed by ReproSalud in consultation with the Policy Project. Finally, another qualitative approach to evaluating the impact of advocacy activities is to conduct a second round of situational analyses to identify any changes in the quality of services that can be attributed directly to advocacy activities.

# 6. THE *AUTODIAGNÓSTICO* METHOD AS A MONITORING AND EVALUATION TOOL

One of the key innovations developed by the ReproSalud project is the *autodiagnóstico.* It is a participatory methodology that involves women, through their community-based groups, in identifying and setting priorities for their reproductive health needs and solutions. The *autodiagnóstico* also allows project staff members to gain insight into women's perceptions of themselves and their bodies. The three goals of the *autodiagnóstico* are to (1) provide women the opportunity to identify their most pervasive and serious reproductive health problems and potential solutions, (2) contribute to the empowerment of women participants, and (3) generate information and understanding about women's lives from their point of view. The *autodiagnóstico* is a series of four half-day workshops that are held with 20 to 25 representative members selected by the CBO. The workshops are facilitated by regional staff members who have been trained in the use of a standard method. The chronology and the content of the sessions are presented in Appendix G.

The *autodiagnóstico* techniques provide a rich description of the fabric of poor women's lives. ReproSalud hopes to use this information for project implementation purposes (to identify women's health priorities), and for research purposes (to characterize women's understanding of reproductive health and life situations). Both objectives require obtaining reliable information, which means obtaining accurate and consistent data from transcripts, notes, and observations made during the *autodiagnóstico* workshops.

Assessment of the validity and reliability of data collected in the *autodiagnóstico* sessions was a specific task identified for this consultancy. Thus, two Team members (Caro and Posner) attended the first two sessions of an *autodiagnóstico* workshop held in Nueva Requeña, a community about 50 km from Pucallpa in Ucayali province. Our comments on the *autodiagnóstico* method focus on its usefulness as a research and evaluation tool. Recommendations in this section are geared toward improving implementation of the *autodiagnóstico* sessions (reliability). Our suggestions are based on observing two *autodiagnóstico* sessions (led by an inexperienced staff member) and an examination of the *Guia del Autodiagnóstico* (MMR, 1997), which is the operations manual. We identified a number of areas of concern and have recommended certain methodological revisions in each case.

***Insufficient personnel present.*** The *autodiagnóstico* sessions would benefit from having additional staff members to monitor small group activities. In the sessions the consultants attended, three age groupings were used to divide the larger group into smaller ones for the programmed activities (e.g., life histories, drawings, and discussions of reproductive health organs). Two staff members moved from group to group but did not stay with a particular group long enough to ensure that the goals stated in the manual were achieved. Without guidance, groups either made progress because one or two members took over completely, or got bogged down on inconsequential details. Some of the questions identified in the manual were not

answered in the small groups because the women did not remember what was said to them at the outset, or the women got involved in tangential issues.

***Recommendation.*** We highly recommend requiring that three trained staff members be present to monitor an equal number of subgroups. When that is not possible, we recommend that group leaders prepare a list of questions that small groups can refer to, and that the leaders monitor groups by regularly rotating between groups.

***Taping the sessions.*** Tape recordings of the small group and plenary sessions are critical. They provide an objective record of the discussions. Unfortunately, it was our impression that these recordings may often be incomplete and of poor quality. In one of the groups observed, no one was specifically assigned the task of monitoring of the tape. Because the session ran over 30 minutes and the women were engrossed in discussion, the tape was not changed for some period of time. Thus, a complete record of the valuable on-going discussion will not be available. This situation is probably not unusual; monitoring of the tape is always likely to be spotty. Using 60- or 90-minute tapes is one option, but better quality recorders should also be considered. Noise within the room (three groups talking at once), and outside (heavy rains) probably also contributed to poor sound quality.

***Recommendation.*** We recommend using high-quality tape recorders and longer-running tapes. We also recommend stressing the importance of quality tape recordings of group discussions in staff training and in the manual. Having additional people available will contribute to better-taped events.

***Methods of implementation may be inconsistent across sites.*** Regional staff members appear to have a great deal of latitude in interpreting the manual and in making methodological decisions that will affect outcomes. If the *autodiagnóstico* is to be used for research purposes in addition to project implementation, it is critical that more standard ways of conducting the sessions be adopted. This standardization is needed particularly for those activities within the *autodiagnóstico* that produce information that the project might use to evaluate impacts, such as "What characterizes a happy woman?" or life histories or possibly women's descriptions of health services. The manual currently provides guidelines, but they are often not stated strongly or explicitly enough.

***Recommendation.*** Revise the "*Guia del Autodiagnóstico*" to identify and describe procedures that will be used in a more standard way across all sites. This is not to say that some types of variations would be disallowed—a concern raised by those who have developed the method. By now, a number of successful methodological variations on the proposed activities have been identified and shared with the central office. Acceptable variations on standard procedures could also be included in the guide. However, the manual should describe the conditions under which these procedures can be used. It will also be important, if ReproSalud hopes to publish case studies using the *autodiagnóstico,* that regional teams document sessions in which alternative methods have been used and why they were chosen. If the sessions are repeated with the same

group at a later time, they should be repeated using the same procedures. In fact, regional teams should understand why more standard procedures are being instituted, so that they "buy into" the process.

The object of a revised guide is to produce more consistent data across sites. A revised guide should clearly define the following:

- How the sessions should be run
- What alternatives are acceptable and when
- What materials will be used
- How many small groups there will be
- Which age groups are to be included
- What number of trained staff members will be present
- What directions will be given to each group for each activity and which questions will be probed during the sessions
- What degree of participation is expected of the staff member present in the group (when to intervene and when not to)
- What the importance is of using the tape recorder reliably as a backup
- What are the number and duration of activities (a range could be given)
- What to do if a group does not finish in time

The revision of the manual will, in fact, be an ongoing exercise (problems will continue to be encountered and changes should be made, if necessary—e-mail is useful for keeping regional staff members aware of any changes that should be made in the manual). Once the task of revising the guide is completed, "hands-on" staff training should take place.

***Ongoing staff training.*** Staff training is another area that would benefit from some standardization and from continuing education and supervision by the central office. Leading a session requires considerable skill; some hands-on practice is essential, but practice sessions should not occur with actual intervention groups. If high standards are not adopted, the quality of the data will be affected.

***Recommendation.*** ReproSalud might consider developing a process of certification in which candidates attend several *autodiagnóstico* sessions led by trained staff members and then pass a series of tests related to the process. It would be ideal if trainees could identify small groups and conduct minipractice sessions with them. These sessions would be observed and critiqued by experienced staff members. Finally, there is the problem of methodological drift. In most long-term research projects, investigators worry about data collectors who inadvertently develop nonstandard ways of obtaining information over time. This methodological drift is especially problematic when there are multiple sites and they are not under the close supervision of those who have established the methods. Retraining and certification should occur on a regular basis to avoid this problem.

***Too much data.*** The project has struggled with what to do about the lengthy tape recordings. Transcriptions from the regional offices have been sporadic and uneven in quality. The Manuela Ramos staff is now contemplating transcribing all the *autodiagnóstico* tapes in the central office in Lima. The advantage of that strategy is that it will produce a more standard transcription that could be used to compare experiences across regions. A disadvantage is that regional offices are likely to miss much of the information that would be valuable for further implementation of activities, which they currently become aware of only when they listen to the tapes after the sessions.

***Recommendation.*** An alternative to transcribing in Lima or to continuing with the poor quality and quantity of transcriptions from the regions is for the central office to develop guide questions from which transcribers in the regional offices will be able to extract the most-important, research-related data from the recordings. The questions could structure the type of information that MMR uses to improve implementation, such as local terms and concepts, information on gender roles and identities, and women's perceptions of their bodies. If that type of information were extracted at the regional offices using a standard method, it would prevent a long time lag between transcription in Lima and application of the information for subproject design and implementation. Some consideration must be given to checking for the reliability of the transcriptions. For instance, one or more individuals trained in listening for information of interest (preferably someone who has not participated in the session) would transcribe taped sessions. A second person would independently transcribe 25 percent of the sessions. The transcriptions would be compared and discrepancies resolved through discussion, which is a standard procedure in research and a minimal requirement for any publications using these results.

***Important information not tracked.*** The *autodiagnóstico* sessions yield considerable information on how women cope with difficulties in their lives. Very little of this information is applied to the design and implementation of subprojects. Such information points out aspects of women's lives where they exert some control, as well as the ways they are disempowered. It is critical that the project not overlook this information but use it to identify resources and power that participants can use and can apply in other spheres of their lives. Similarly, ReproSalud can tap into some of the ways that men are disempowered in their relationships with national authorities, with other socioeconomic groups, and in the workforce to help men understand how their actions affect women within their communities.

***Recommendation.*** The project should develop an inventory of ways that women are currently empowered in particular contexts and relationships. Ways to apply this information in the design and implementation of project activities should also be determined.

***Recommendation.*** ReproSalud should identify which of the sessions produce information that will be used to evaluate changes in individuals and in the group. We suggest that key sessions be

repeated after 12 to 18 months, and again at the end of the project.[6] It would be interesting to see how and if characteristics that women ascribe to a “happy woman” change, or how their understanding of reproductive physiology has been affected. Similarly, it would be interesting to compare whether the descriptions of women's life stories change: Is the birth of a daughter valued differently? Are women's reproductive health options broadened? Do outcomes of decisions change? Are relationships with and the roles of partners and parents described differently from how they were described in the original *autodiagnóstico* workshop? Repetition of key sessions of the *autodiagnóstico* workshop at later points in the project would also provide an opportunity for the facilitators to observe group dynamics to see if those undergo a change as well: Do more women participate in discussion? Or do they participate differently from the way they did during the first *autodiagnóstico* session?

[6] It may not be possible to include the same women during a second round, but it would be desirable to try to include as many of the same women as possible. However, since many of the concepts that are of interest are shared widely within communities, the expectation of the project is that the project intervention will affect the group and the community (including other members) in similar ways, but will not jeopardize the results. This research would seek to investigate group, rather than individual, changes.

# 7. THE BASELINE SURVEY AND PLAN FOR ENDLINE AND INTERMEDIATE IMPACT STUDIES

## 7.1 Baseline Survey as Currently Implemented

***Background.*** ReproSalud received funding authorization in August 1995, and eight regional offices were established in early 1996. In September and October 1996, 17 communities were selected as candidates to develop subprojects. By December, those sites had completed the first step in ReproSalud's methodological sequence, the *autodiagnóstico*. All of the subprojects focused on community-based education in reproductive health themes and were underway by the first half of 1997.

Efforts to evaluate the impact of ReproSalud's activities with communities were initiated in December 1996. At that time, an outside consultant was hired to work on an evaluation plan, develop an instrument for a baseline survey, and organize an Evaluation Unit for the project. To facilitate this work, Mission and ReproSalud staff members provided the consultant with a conceptual framework that included a list of 16 assumptions regarding the women targeted for project activities and the processes by which the proposed project activities would operate to change key behaviors (Brems and Feringa, Memo 1997).

Using this description of hypothesized outcomes, the consultant worked on an evaluation plan that focused on obtaining baseline data using survey techniques. A specific research plan was not elaborated, but the general idea was to conduct a baseline survey in the early stages of the project and a final evaluation in the last year. The consultant developed a questionnaire and, in August and September 1997, completed 400 surveys with women who were then involved in subprojects. ReproSalud staff members were not satisfied with the consultant's work, and his contract was not extended.

During this period, a search for a permanent staff member who would head the Evaluation Unit was also conducted. In September, Alejandro Bardales was hired. The first problem he faced was whether to continue data collection on the baseline survey. Having identified ambiguous and confusing items in the questionnaire and problems in the methods used in data collection, he decided to call a halt to the survey, discard the surveys that had been completed, and work on revising the instrument. The revised instrument clarified items related to reproductive health and added items on domestic violence, empowerment, income generation, and advocacy that were not in the original instrument. The new questionnaire contains more than 500 items, as compared with 67 in the original instrument. In general, the Team believes that the length of the questionnaire may affect the reliability of the responses. In addition, many questions appeared ambiguous or weakly related to reproductive health objectives. We have suggested eliminating some sections of the questionnaire (see Chapter 3). One important inclusion in the new questionnaire, which permits different types of designs, is the ability to identify each respondent uniquely. In addition,

different versions of the questionnaire were created for women and for men. Piloting of the revised instrument was completed in Lima, and fieldwork was begun in November 1997.

***Sample selection***. The sampling procedure used for the revised baseline survey was determined on the basis of the size of the primary CBO and the population of the communities in which they operated. At small- or intermediate-sized sites, in which the population was less than 2,000 inhabitants, two strata were sampled. The members of the CBO and their families represent the first stratum. When the CBO was small (less than 40 members), all women between the ages of 15 and 49 were interviewed, in addition to all male and female members of their households between the ages of 15 and 49 (if female) or 15 and 59 (if male). When the CBO was large (over 40), a random selection of a large proportion of its members and their households was sampled in the targeted age groups. For example, when the number of CBO members was 60, 80 percent of the women were sampled. The number was calculated using a standard statistical formula for determining sample size, the same formula is presented in Appendix H. The second stratum corresponds to other members of the community. When the number of non-CBO households in the community was less than 40, all households were sampled. When the number of nonmember households was 40 or more, the formula described above was used to determine the number to be sampled.

Seven first-round subprojects were located in areas with populations greater than 2,000 inhabitants. At those sites, only women in the CBO and their families (or a proportion of women and their families when the CBO was large) were surveyed, as it was not clear how to operationally define the "community." At some of these sites, members of the CBO lived in different neighborhoods scattered across the city. In a case like this, the most obvious solution, sampling the neighborhood in which the CBO itself was located, would not have been an appropriate proxy for the target "community."

***Data collection.*** By the end of December 1997, 60 communities in eight regions were surveyed, and well over 4,000 individual questionnaires were completed. Those communities represent virtually all sites in which ReproSalud initiated subprojects in 1996 (17) and 1997 (53). A field director, eight regional supervisors, and a team of interviewers were hired for the data collection. The average cost per community was estimated at US $1,300. This figure does not include the field director's salary or the time the head of the Evaluation Unit has devoted to the effort. Without these inputs, the cost of the data collected to date comes to more than US $70,000. This amount may not be excessive when compared to other studies being conducted by the project; however, it is still not clear how much of the data collected can actually be used in the baseline study, or how many more sites are intended to be included in the baseline sample. In 1998, 55 new communities are targeted to initiate subprojects (Bardales, 1998). If the same design and sampling plan were used, as many as 4,000 additional surveys (or more) might be added to those completed last year.

On the basis of the data collected thus far, the following issues should be considered in designing an overall evaluation study. The head of the Evaluation Unit has a very good understanding of the

methodological issues that are involved and has, in fact, identified some of them. What we have tried to do in the next section is identify possible problems and to present alternatives for addressing them in a design.

## 7.2 Methodological Issues and Recommendations

***Representation of communities of different sizes.*** In the Results Framework, the community is identified as a focus of interest in three of the four intermediate objectives (IR 1; IR 1.1; IR 2.3; IR 3.1; IR 3.2 and IR 3.3). Clearly, determining the impact of project activities on members of the larger community (beyond the members of the CBO) is seen as important. We understand this approach to imply that, for many variables of interest, community will be the unit of analysis. The challenge for evaluation is to adequately conceptualize and represent "community," given the considerable regional differences that exist in the size and structure of project sites. We will suggest several approaches and the possible effects they would have on results.

Sites where first-round subprojects were undertaken in 1997 varied greatly in size as Table 2 indicates. A quarter of the projects were located in communities with fewer than 50 households, 32 percent had between 50 and 100 households, 28 percent had between 100 and 500 households, and 15 percent were in sites with greater than 500 households. In small villages, the likelihood of a few trainers being able to involve most members of their community in educational workshops is high. At very small sites (fewer than 50 households), CBO members and their families actually constitute the community, and the degree of contact that they have with the project staff during the grant cycle is intense. A priori, compared to large sites, the effect of project activities in small sites will be greater **when community is the level of analysis**.[7] That is, in statistical analyses in which variables are aggregated by community, the influence of very small communities will be disproportionate to the number of people they represent. For example, if contraceptive prevalence (proportion of women using a modern method) were compared across communities that have participated in the project, the proportion contributed by small communities would be of equal weight to those contributed by larger communities. If homogeneity of variance across sites can be demonstrated, doing an analysis of this type would not be an issue. However, it is precisely this issue that may pose a problem. In very small villages, most women will receive project interventions directly and intensively, so one would expect the variance to be low. In larger communities, not all community members will be as directly involved in the project, thus variability of this and other important variables (knowledge about reproductive health, level of empowerment, extent of health service use) will likely be greater. If it is too great (a rule of thumb

[7] In a combined analysis in which every member of the communities in a sample is represented and given equal weight (that is, in an analysis in which the individual is the unit of analysis), the issue of different-sized communities would not be a statistical concern (especially using the current plan, which includes virtually the entire population in the sample). However, significant differences may be difficult to obtain in a combined analysis unless level of participation in program activities is incorporated as a factor in the design (see Appendix E for more discussion of this issue). In that case, one would expect differences within certain groups (active CBO members) to be much greater than in others.

is twice that of other groups being compared), results are compromised. Note that we do not mean to imply that this is an issue that would be overlooked by the Evaluation Team—it is simply brought up as an issue of potential concern.

**Table 2**

**Characteristics of Different Sized Sites Represented in Cycle I Subprojects Sampled in 1997[a]**

| Size of Site: No. of Households | Small[b] (<50) 50–100 | Intermediate 100–500 | Large[c] (>500) |
|---|---|---|---|
| No. of Sites | (13) 17 | 15 | 8 |
| Average No. of Households[c] | (34) 71 | 199 | 1821 |
| Average No. of Eligible Women and Men[c] | (62) 141 | 290 | 3656 |

[a] In Cycle I (1997) 53 sites were involved and are included in the baseline sample to date. Data were provided by Alejandro Bardales of the Evaluation Unit.
[b] Information on sites with fewer than 50 households is shown in parentheses; small sites with 50–100 households are not in parentheses.
[c] In the case of large sites, 2 of the 8 sites were the same; therefore, the average number of households and of eligible men and women were calculated using 6 sites. Only 14 of the intermediate sites had information on the number of men and women.

One suggestion to consider in addressing this issue would be to include sites (in the sample) in which only a certain number of non-CBO households are available. The "community" could be defined as two times the number of CBO households. Fixing the number at two times, the active CBO members would result in an equivalent number across sites. In very small villages that do not have the required number of households, sites of their sister CBOs could be added to the sampling frame. Subprojects are required to involve organizations from other communities (in urban zones, from other neighborhoods), but those other communities do not presently figure in the sample. Nor does it appear that sister CBOs participate in project activities to the same degree as the primary CBO; therefore, they may be affected differentially. This concern can be addressed in the selection process. CBOs from very small villages could be asked to join with other CBOs in applying for subproject funds, and both would act as equal partners in all phases of the project.

***Baseline data collected after the initiation of the main intervention.*** Baseline data on the first subprojects were obtained at **variable** points across the programmatic sequence. The sequence involves four main steps in which most active members of the CBO participate: (1) *autodiagnóstico,* (2) project development, (3) training of CBO members, (4) selection of trainers, and (5) replication of training. Although the most logical point at which to collect baseline data is

before the *autodiagnóstico*, only some CBOs were surveyed at this point.[8] Hypotheses regarding the impact of participating in different steps in the programmatic sequence would be helpful in determining whether the surveys obtained at different points in the project should be retained as "baseline" data or not. It may be that participating in the *autodiagnóstico* does not affect attitudes or behaviors; however, it is stated in at least one project document that the *autodiagnóstico* session is designed to empower women by affirming their capacities and potential (e.g., *Informe de Evaluación Anual del Plan Operativo*, 1996). This empowerment could be tested by comparing groups that have and have not been involved in the sessions. If no differences were found, the data from sites sampled after the *autodiagnóstico* (n = 33) could reasonably be retained. However, from a programmatic as well as an evaluation perspective, it is probably not reasonable to consider individuals who have actually participated in the main training workshops on reproductive health (the education component of the subprojects) as having a baseline understanding
(n = 15).

***Recommendation.*** We recommend that surveys collected after training in reproductive health began be excluded from the baseline.

***The replication effect in urban areas.*** According to the sampling plan (Bardales), "community" was not assessed in urban areas with populations greater than 2,000, because the "zone of influence" of CBO *promotoras* in urban areas was not easily defined. Although there have not been too many CBOs in this category to date (of CBOs sampled in 1997, 453 were located in sites with populations greater than 2,000, and 4 more had populations greater than 500), it is possible that periurban communities will be of greater interest as the project matures.

***Recommendations.*** We recommend asking CBOs to describe, in the proposal, the community they think they represent (and where they are located), just as they are asked to include sister communities with which they will work. Identifying intended targets is a standard component of proposals. In cases where the CBO members cannot delimit specific target groups because the community is dispersed across a populated area, sampling two or three of the CBO members' neighbors might be considered as a reasonable proxy.

[8] Information provided by the head of the Evaluation Unit reflecting all CBOs surveyed through May 1998 indicates that of 68 communities, 16 were sampled before the *autodiagnóstico*, and 33 were sampled after the *autodiagnóstico*, but before any educational training occurred.

## 7.3 Design Options for the Baseline and Subsequent Surveys

An overall design for an evaluation study has not been specified. Many elements of an evaluation study still need to be determined. These elements include how (or if) sites will be sampled, what the cutoff for baseline data will be (if any), what the comparison groups will be (if any), how many assessments are to be made, and how differences in types and number of interventions will be handled. In each of the following sections, we suggest relevant design options.

***Sampling.*** The strategy being used at present is to survey every site in which subprojects have been initiated. This approach is more like a monitoring strategy than an evaluation plan.[9] Not only is this a costly, time-consuming procedure, but it is also unnecessary from a statistical standpoint.

***Recommendation.*** Adoption of a sampling plan that reduces the number of sites represented in the sample is recommended. The technical advisor to ReproSalud at the Mission suggested that regional representation would be desirable because of cultural and ecological variations across regions. In a stratification based on regions, a random sample of communities in each of the eight regions would be selected, and differences across regions could be examined specifically or controlled in statistical analyses. We believe that the need for regional representation should be considered further. Stratification is important when extreme differences in the population are expected. When expected differences are smaller, simple random sampling might be a better option. However, if regional stratification is used, at a minimum, two sites per region must be included in the sample. The actual number required depends on what the study is measuring, the precision required, and a number of other issues related to the type of study that is undertaken. We are not recommending using two.

The sampling units selected within regions must be equivalent. As noted, the project works with communities of very different sizes, but in urban areas it is not always clear what constitutes the target community. Adopting an operational definition of community (i.e., twice the number of active CBO members) is a convenient way of achieving relative equivalency. The system currently used to sample CBO members and their families would be retained if the number of individuals sampled in large and small CBOs does not vary too much or if it would be possible to add to the sample in ways described above. Ideally, the number of active CBO members would be about 40. This number could be kept in mind in selecting sites for subprojects, as noted above.

The number of people who are in each community and who are needed to detect differences on specific indicators can be determined using statistical tests. Using the community size proposed above (40 members, 40 husbands, and 80 others), we conducted analyses to determine the

[9] In responding to a preliminary draft of this document, the head of the evaluation indicated that the idea behind interviewing all CBOs was to have sufficient data available to group together families of CBOs that have had similar interventions and then examine the effect of specific interventions. We do not think that it is necessary to group CBOs by intervention type, as the interventions, at least to this point, do not vary greatly, and, as is suggested below, the object of the evaluation should be to examine the overall effect of the project, rather than specific types of interventions.

minimal sample size necessary to examine contraceptive prevalence in two of the eight regions, Ucayali and Huancavelica. The data we used on contraceptive prevalence rates came from regional reports of the 1996 *Encuesta Demografica y de Salud Familiar* (ENDES) that was disaggregated by rural and urban zones (*Instituto Nacional de Estadistica e Informatica* [INEI], 1996). Appendix H provides the formulas and calculations used to determine the numbers given as examples here.

Our analyses showed that in Ucayali, 98 people in the community are required to detect differences with reasonable precision (.10).[10] In Huancavelica, the minimum number necessary is much smaller (n = 45). If regional stratification is adopted and approximately one-third of the communities targeted for 1998 (n = 55), plus those from 1996–1997 in which data were collected before the *autodiagnóstico* (n = 7) are included in the sampling frame, three communities per region could be selected to represent the baseline. (This assumes equal distribution of subprojects across regions, as was the case in 1997—if districts do not show a similar number of subprojects, then a representative proportion by region is suggested). This is a relatively conservative approach, because about 480 people would be available for analyses at regional levels when collapsed across communities if the definition of community is acceptable. Again, the type of study design has to be considered in determining the numbers needed. Panel or repeated measure designs sample the same individuals over time, and rates of attrition must be factored into the sample. Cross-sectional designs do not require the same individuals; thus, using the minimum number would be adequate. If a panel study is conducted, a conservative estimate of sample size is warranted, because locating the same respondents will not always be possible.

***Cutoff for baseline data.*** Focusing the baseline study on a sample of communities targeted for projects in 1998 (including certain communities already sampled in 1997) will permit the Evaluation Unit to obtain data before the *autodiagnóstico* is conducted. It will also set a limit on the collection of baseline data. If 3 communities per region (24 in all) were selected as a representative sample, the time and costs given to the evaluation effort would be cut substantially, when compared to the current approach.

***Comparison groups.*** Whether to use control groups in the evaluation design is an issue that has concerned project staff members and others interested in the project from the outset. The decision should be based on what the evaluation attempts to demonstrate and what constraints must be

[10] The level of required precision (confidence interval) used in demographic health surveys is often higher, but .10 is generally acceptable in project evaluation research. This is because the effect of a bias on the accuracy of an estimate is relatively negligible if the bias is less than 1/10 of the standard deviation of the estimate (Cochran, 1963). However, there is a large difference in the number of people required for .10 versus .05 level of precision that would greatly affect cost. As this study is not primarily one to determine the prevalence of contraceptive use in regions with the goal of determining regional health policies, in the way that a DHS survey does, the additional cost does not seem warranted. Furthermore, there is concern in the field that confidence intervals are sometimes used to justify generalizing results to more general populations (the region, for instance), when, in fact, the sample selection process does not justify it (Abramson, 1994). In the case of this study, it will not be possible to generalize the data further than the sample of communities from whence it was drawn.

overcome in designing a valid study. If the goal of the study is to show that participation in the project causes changes in reproductive health indicators, then the use of control groups is necessary. As has been noted by others (Foreit, 1996), there are downward trends in many of these indicators that could not be disentangled from the intervention effect if comparisons with a control group were not conducted.

Identifying adequate control groups is not straightforward. The process for selecting the districts in which the project will work is based on sociodemographic factors (poverty rate, fertility rate, population density); the number and characteristics of women's groups represented across the district; and the accessibility and security of the area. Initially, ReproSalud staff members selected two provinces in each regional department (with the exception of Ucayali), and two to five districts within each province. The same selection process must be used to identify control sites, because many of the selection criteria are likely to covary with key outcome variables. Regional offices have already gathered much of the sociodemographic information that could be used to identify additional sites, but a number of other factors must also be taken into consideration.

Choosing control sites in districts where the project is already working is not desirable because of possible "contamination" effects. Electing districts that meet the criteria but do not currently have ReproSalud projects would restrict the project from moving into them later on. The best option seems to be to focus on other provinces in the department that have similar sociodemographic characteristics. In Huancavelica, for instance, only three of seven provinces were selected. One way to see if it is possible to match for sociodemographic criteria in a province not selected is to revisit the data collected in the situational analysis of each region. Examining why provinces were rejected would be the first step. For instance, poor accessibility might have been a reason for deselecting a district for intervention but might be a positive factor in choosing control groups because other development projects will also be hindered from working there. Finally, it is possible to control statistically for systematic differences that are observed between intervention and control sites. It would not be necessary to sample the same number of control groups as intervention groups; one well-matched group would probably be adequate. Thus, while identifying adequate control groups is not easy, it does not appear to be an impossible task.

Linking changes in knowledge and behavior directly to project activities will not be possible unless it can be established that outcomes are because of participation in project activities alone. Even in the few sites visited by the Team, various projects were underway that contribute to women's empowerment and income in the same way that project activities are intended to do (e.g., income-generating projects in fish farming and sewing). In addition, the Program of Support in Reproductive Health (Programa de Apoyo en Salud Reproductiva [PASARE]) and Project 2000 are involved in efforts to improve reproductive health and quality of services in the same departments, so there may be overlap in these domains. It will be important to maintain records on the activities of other projects in intervention districts to test for synergistic effects. This possibility was mentioned in the Project Paper. Notwithstanding, because nonproject activities probably will not occur uniformly across intervention and control groups (or even within groups), it will be difficult to control for their effects statistically. Thus, outcomes associated with the

intervention groups (as compared with the control groups) could not be said to be caused by the ReproSalud experience. Note that assigning causality will be a problem for other designs as well. A panel study that examines changes in the same women's health behaviors over time would also be affected by outside influences.

***Recommendation.*** What would be gained by including a control group is that the differential effect for ReproSalud groups over and above control groups could be determined. Thus, we recommend including control groups in designing the impact study.

***Number of assessments.*** It is possible to conduct both repeated measures and pre- and post-analyses with controls if the same individuals are sampled repeatedly over time in the intervention groups and if a cross-sectionally selected control group is included in the design. Differences between the intervention groups' baseline and endline assessment ($I^2$–$I^1$) would be compared to that of the control group ($C^4$–$C^3$ ). If, for example, men and women in the intervention group are also assessed at other points during the project, then some parts of the survey could be administered after the second subproject and again after the third (if there is one). Therefore, changes in some variables could be tracked over time ($I^3$–$I^2$–$I^1$). In repeated measure analyses, the individual serves as her or his own control, so there is no need to track the external control group. Nor would it be necessary to sample all intervention sites repeatedly; sites within one or two regions could be identified for the panel study.

***Type and number of subprojects.*** One of the issues previously identified as being a problem (Foreit, 1996) in evaluating ReproSalud is that the type and number of interventions undertaken in communities during the life of the project would be so varied that there would be no way to use a classical quasi-experimental design comparing intervention groups to control groups, as though the intervention groups were equivalent. From our vantage point, this variation is not as problematic as it may have appeared earlier in the project. For one thing, we now know that virtually all of the first-round projects have been community education projects. The central theme varies, but all communities receive the same basic reproductive health messages, although there are differences within groups as to the degree of exposure. According to Mission staff, second-round projects will probably also contain educational components, as well as other activities that are unknown at the moment. Whether there are differences is not a crucial issue if one compares intervention groups with control groups. In many quasi-experimental studies, "treatments" are not equivalent. For instance, one member of the team directed a large study of low-income children's after-school activities in which the main "treatments" were children who went home to mothers, children who attended after-school programs, and children who were home alone. None of the groups were completely equivalent, but they were more similar to each other than to the other groups. The research showed that there were important differences between groups (Posner and Vandell, 1994).

In the case of ReproSalud, a main expectation is that communities that have had interventions will show differences over and above those that have not. Another hypothesis is that the number of subprojects conducted in a community will affect the intensity of the effect. These are outcomes

about which project staff and outside stakeholders are interested. Another possible question is "What type of intervention is most effective?" It is important to keep in mind what ReproSalud hopes to do as a project. Although the project embraces different interventions and wants to know that, overall, they are having an effect, its purpose is not to compare them, nor is it best suited to do this. An evaluation of ReproSalud should not be approached as if it were an operations research effort.

***Recommendation.*** On the basis of the above considerations, we recommend adopting a design that includes external control groups, but also identifies some of the same women sampled in the baseline and endline surveys for a panel study that examines changes in women over time.

# 8. GENERAL ISSUES AFFECTING IMPLEMENTATION AND EVALUATION, PLUS CONCLUDING REMARKS

Up to this point, we have been exploring and defining the given dimensions of the ReproSalud project, its background, and the Results Framework. We have suggested independent variables and proposed indicators. We have been examining ways to measure what we expect to be happening as a result of the project's implementation. In this section, we consider several issues that may inadvertently affect the overall measurable impact of the project.

## 8.1 Representativeness of Women Involved in ReproSalud's Programmatic Sequence

The Evaluation Team looked at the question of how representative of the project's target population are the women who become most directly involved in the programmatic sequence of ReproSalud. We know that the screening process for the selection of the CBO is highly selective. It attempts to identify the most dynamic and organized women's groups in a district. Many of the CBOs selected have more than 40 active participants. When CBO membership exceeds about 25 members, the CBOs are asked to select approximately 20 members to participate in the *autodiagnóstico*, the first step in the programmatic sequence of ReproSalud. For the second step, design of the subproject, it is preferred that the women who attended the *autodiagnóstico* also attend the design activities, although other women may also attend. Again, participation in the subproject design is limited to approximately 20 persons. Capturing differences in the degree of participation in the programmatic sequence is critical to identifying differential levels of project impact on women and others in the community. Suggestions for quantifying this and other important independent variables—degree of male participation in project activities, degree of access to additional economic resources through participation in ReproSalud's income-generating activities, and degree of specific skills training—are presented in Appendix E.

Other effects related to the selection process are also a concern. Within the CBOs, it is more than likely that those women with greater leadership potential, more disposable time, and probably higher literacy rates and more stable relationships will be further selected as participants in the programmatic sequence of ReproSalud.

Whether the women selected do, in fact, have higher literacy rates and more stable relationships (i.e., single, with partner, separated, or widowed), could be checked rather quickly from data presumably already available on the CBO membership. If such a database on the CBO does not exist, it should be developed immediately.

The way this issue may indirectly affect measurable project impact is explained as follows: Women who participate most directly and fully in the programmatic sequence of ReproSalud may be those women whose behavior with regard to reproductive health is either (1) already closer to the desired behavioral outcomes than that of other women in the community, or (2) much less

likely to change because of pre-existing factors. For example, recent observations during the *autodiagnóstico* in Nueva Requina indicate that the young women who attended are already using modern methods of birth control. To be doing so suggests that they must also be accessing health facilities. It is also not uncommon for post-menopausal women to participate in ReproSalud's programmatic sequence. To the extent that these patterns are true for other areas, this participation means that up to 40 percent of the women who are directly involved in the programmatic sequence are not truly the target population.[11] Although they are among the hard-to-reach women, other factors put them beyond the range of the target population. Their reproductive health care and family planning behavior are unlikely to change no matter how successful ReproSalud is in promoting awareness, informed choice, and a desire for such change.

At the same time, women who do not appear to be participants in the programmatic sequence—but some of whom would be part of the target population—are unpartnered female household heads. (This observation is inferred from the fact that where training of the men took place, the number of men included was nearly the same as the number of women in the *autodiagnóstico,* and they were referred to as the partners of the women who participated.) According to data cited in the project paper, however, unpartnered female household heads constitute between 26 percent and 32 percent of the household heads in several project areas (28 percent in Puno). Although it is possible that many of these women are older widowed household heads, it is still likely that a good number of them may be younger women of childbearing age who have been abandoned or who have chosen not to marry. (In a small community in the highlands of Ecuador, for example, several women had stable relationships and more than one child by the same father but refused to live with their partners or to marry because they did not want to relinquish title to land they held in their own names.) These are women whose behavior might be influenced, but who may be unable to participate in the activities of ReproSalud, perhaps because of the daytime activities. Or it may also be that unpartnered female household heads are less likely to be members of the CBOs in the first place and, therefore, are unable to be selected as participants. (It should be possible to explore these questions in the situational analysis where that has not yet taken place.)

***Implication of the issue of representativeness.*** One of the three basic hypotheses of the conceptual framework of ReproSalud is that "women who experience the programmatic sequence will make greater use of reproductive health services than they did before." Nearly all the indicators listed in that framework (with the one exception of the lower prevalence of reproductive tract infections) focus on women who are in their most active childbearing years. If approximately 40 percent of the women in any CBO who participate in that sequence are unlikely to show behavioral changes, however, even a most successful project may show a much more diluted impact. In fact, to the extent that the replication activity is successful, the project may show a comparable or higher degree of impact among those who participate less and may not

[11] In any group of 20 adult women (18–65+), one could expect about four women to be above 45 and four below 25 years of age (40 percent) according to probability.

even be members of the CBO. This outcome would contradict the predicted direction of the hypothesis and undermine the importance of participation in the programmatic sequence.

***Recommendation.*** A number of CBOs have already completed or are about to complete their first subprojects or, in other words, have gone through three major steps of the programmatic sequence. It is recommended that a more in-depth study addressing the issue of representativeness and the questions it raises be undertaken as soon as possible in one or more of those communities. If the concern about representativeness is shown to be warranted, then steps should be instituted as quickly as possible to address them.

These steps might include, but would not be limited to, the following:

- Consider rethinking what may actually be happening and reformulating the hypothesis, or breaking it down into smaller component parts.
- Analyze findings by age cohorts (<26, 26–30, 31–35, 36–45) as well as by degree of participation.
- For replication activities, consider whether late afternoon or evening sessions could be offered and whether those sessions would attract women not able to attend at other times.

Although one correction mechanism might be to limit the attendance of women 40 or older in the programmatic sequence, this limitation is not advisable. The participation of older women could be very important in terms of social approval for ReproSalud's activities, particularly in rural areas. Older women may also be key to creating normative changes in the community that will allow women of reproductive age to act on their changed intentions. Especially in the *sierra*, older women are likely to have more political influence than younger women, and they may also be able to directly influence their daughters, sons, and daughters-in-law. Older women are more likely to be spouses of the male community leaders and may have an effect on their attitudes as well.

## 8.2 Community-Level Sustainability

In project areas visited, ReproSalud project staff members are already clearly overextended. They wonder aloud about how they will manage to incorporate the next cycle of CBOs this year, and they dare not yet think about the upcoming group for next year. At the same time, the programmatic sequence, as currently conceived and implemented, is highly labor intensive on the part of the regional teams. The regional teams or select members guide the *autodiagnóstico*; lead the subproject design activity; train the promoters; and then work with the promoters to plan, support, and, often, assist them as they conduct the first cycle of replication activities. Where the communal banks exist, there is an additional team member who, after training the bank's administrative staff, attends each monthly meeting of the communal bank.

An interrelated series of questions emerges here regarding how dependent the project's success is on continued interaction from community outsiders, specifically, ReproSalud's regional teams:

1. At the level of the district and the collaborating CBO, will the subprojects continue to operate with (a) the same apparent level of success, (b) the same momentum, and (c) the same apparent level of trust as the regional team members become less directly involved?

The promoters are local community members. As regional team members withdraw and promoters are increasingly left in charge, it is unclear whether the promoters will be capable enough to take on the responsibility of organizing subsequent subproject design teams and addressing new topics. Also unclear is whether the community will regard the promoters with the same respect, and whether the promoters will continue to receive financial incentives for their time and for refreshments for those who attend the sessions. There would likely be much variation by communities. This uncertainty surrounding the future of the activities at the community level will probably be greatest if the subprojects continue to be educational in nature.

2. At the level of the district and the collaborating CBO, will the communal banks continue to operate with (a) the same apparent level of success, and (b) the same apparent level of trust as the regional team members become less directly involved?

Concern about momentum should be less of an issue with the communal banks. Once women begin to realize that their resources are increasing through the credit mechanism of the bank, that increase should be sufficient incentive to keep the activity moving forward. What may become the more serious issue for communal banks, however, is trust. As the ReproSalud team withdraws, bank members will have to rely more and more on the honesty and integrity of their bank's administrative committee.

***Recommendation.*** ReproSalud should develop a profile of the characteristics of the village bank members (age, civil status, number and sex of children [under 5 years of age, 5–12 years of age, and over], highest level of education, and primary and secondary occupation). This information could be compared with characteristics of the women who attended the *autodiagnóstico* sessions and subproject design in the same communities. It is possible that village banks and product development activities provide a more viable opportunity for women heads of household, women from more marginal households, or both. If so, their active participation in ReproSalud processes will expand ReproSalud's representativeness and reinforce the sustainability of its activities at the community level.

***Recommendation.*** We recommend that the baseline be re-administered at set intervals before completion of the ReproSalud project. The social sustainability issue argues for this. To the extent that the success of ReproSalud activities is to some degree contingent upon relationships with the regional teams, and that those teams continue to disengage themselves from the CBOs and the communities, the impact of the project in terms of prompting changes in behavior may be greatest around the time of the completion of the first subproject. After that time, the regional teams

should be less directly involved with the CBO and the community. If the implementation of the project at the community level begins to weaken from this point on, the results of the final application of the baseline could show a reduced level of impact. Without intermittent applications of the baseline for monitoring purposes, it would not be possible to verify the occurrence of the (assumed to be successful) intermediate results.

## 8.3 Accessibility and Quality of Health Care Services

One of USAID's central concerns in Peru—and a main reason for designing ReproSalud from the "bottom up"—is that health services are underutilized despite unmet needs of rural and periurban populations. The reasons people do not access services are many, but foremost among them is that the quality of services is thought to be poor. Although we have left this consideration for last, it is undeniably a key factor in reaching the project's strategic objective—"to increase utilization of reproductive health resources by women." The Results Framework reflects this concern. In it, access to quality services appears as the "black box" upon which achieving the ultimate objective depends. The project assumes its advocacy efforts at the national level[12] will influence the MOH to offer better services overall. At the community level, women are encouraged to advocate for specific changes in local health services. It is obvious that there are no assurances that the MOH will respond to lobbying, or that local services would change for the better if they did. As has been noted by other consultants (Rogow and Wood, 1997), this factor must be taken into consideration. We suggest that community members rate their perception of health services and that this variable be used as a moderator or mediator of main effects. A more robust variable could be created by combining several items related to quality care on the survey (e.g., perception of quality, why services are or are not used, degree of use of alternative forms of care). It might also be possible to join with other projects funded by USAID (e.g., Project 2000) to more objectively assess the services offered in health posts connected with communities in which ReproSalud is working.

[12] The Team did not consider indicators for advocacy at the national level because another group of consultants was working on this issue.

## 8.4 Concluding Remarks

ReproSalud is a complex and groundbreaking project comprising multiple components that are hypothesized to contribute to an ultimate strategic objective: women's increased use of reproductive health interventions and resources. In response to this complexity, diverse ways of evaluating the project must be put into action. Because of the novelty of the project's approach, the evaluation methods are relatively unchartered. In preceding chapters, we offer a range of alternatives for evaluating each of the main project components, which should be useful in determining a comprehensive plan for evaluating this interesting and innovative effort.

Overall, we feel that ReproSalud is committed to adopting high standards for evaluating the project. However, a major constraint in implementing suggestions made in this report is that the Monitoring and Evaluation Unit (MEU) does not have the necessary staff to do its job. ReproSalud was not conceived as a research project and, therefore, has not invested extensively in this unit. The coordinator of the unit was hired only recently and has a minimal staff. As the number of subprojects increase, just keeping on top of the continuous monitoring required by the project may overextend the capacity of the MEU. Also, demanding high-quality research is likely to be more than the small unit can handle.

Although some of this work can be contracted out, as has been done to date, it will be important to hire additional researchers to work within the Evaluation Unit. These individuals should have experience in carrying out qualitative and quantitative evaluation research, including analyzing data, conducting comprehensive literature reviews, and publishing results. Also important is identifying social scientists with experience in evaluating reproductive health, women's development projects, microenterprise, and community education, as the project encompasses each of these areas. Researchers who have these qualifications may not be easy to find. However, if USAID and ReproSalud hope to convince international audiences that project objectives are being achieved, investment in strengthening the MEU is critical.

# APPENDICES

# APPENDIX A

## Scope of Work

### I Background

*A) The ReproSalud Project*

Formally known as Reproductive Health in the Community (project number 527-0355), ReproSalud seeks to promote the reproductive health and overall social development of women in Peru, particularly those with disadvantaged socioeconomic status in rural and peri-urban areas A five-year, $25 million effort, ReproSalud is implemented by the local non-government organization Movimiento Manuela Ramos (Manuela), with intermittent assistance from the Centro de Investigacion Social and Educacion Popular Alternativa

ReproSalud's objective is to increase rural and peri-urban women's utilization of family planning and other reproductive health interventions by actively involving them in identifying, prioritizing and resolving their own reproductive health problems The project strives to work with at least 200 community-based organizations (CBOs) in six[1] of Peru's thirteen regions to conduct participatory research that identifies the reproductive health needs of local women Once needs are identified, community organizations choose those that are most important, and with grants and technical assistance from Manuela, develop and implement activities to address those prioritized needs The project complements Ministry of Health services by referring women to them

The project responds to such reproductive health needs as high rates of unwanted pregnancies and births, contraceptive method failure and unnecessary discontinuation, unacceptable levels of maternal mortality and complications from high-risk pregnancies and births, as well as from unsafe abortion, and widely-prevalent reproductive tract infections In the project target areas, total fertility rates are as high as 6 2 for rural women and 7 1 for women with no education Further, the 1991-1992 Demographic and Health Survey indicated that one-third of births -- over one million in number -- that occurred during a 5-year period were not planned And the Alan Guttmacher Institute estimates that over 270,000 clandestine abortions take place in Peru each year, underscoring the need for activities in abortion prevention ReproSalud will undertake the time-intensive, locality-specific activities that are required to make reproductive health services meaningful to local, hard-to-reach women

With an innovative, integrated design, ReproSalud also addresses needs arising from women's political and productive roles that affect their reproductive health status The advocacy component assists women in their pursuit of increased participation in political

[1] These are La Libertad Chavin San Martin Ucayali Jose Carlos Mariategui and Libertadores Wari Activities in Chiclayo and Lima East are also likely to be undertaken

processes by bringing together community groups that face similar problems to dialog and advocate for common causes and by channeling their demands up to higher-level authorities

Women's productive roles are enhanced by ReproSalud's microenterprise and credit component Microenterprise and credit activities linked to reproductive health focus simultaneously on augmenting individual women's and communities' access to resources and on reducing economic barriers to the utilization of reproductive health services

*B) Progress thus far*

In the two years since the signing of the cooperative agreement with Manuela, much progress has been made toward achieving the goals and objectives of the project Based on criteria such as poverty and high fertility, sixteen districts throughout the project's regions were selected to be the focus of the project's first cycle The project was introduced to authorities and communities in each of those districts, and, a competition was held among women's community-based organizations (CBOs) to determine which would be Manuela's local counterpart Thus far, sixty-one CBOs have been chosen and another 65 will be selected as counterparts in 1998

*Autodiagnosticos*, which consist of participatory qualitative research activities aimed at enabling women to identify, analyze and prioritize their reproductive health problems, have been conducted in 55 of the CBOs Prioritized problems have been in three principal areas

1) Vaginal discharge, termed by women as *regla blanca, aguas blancas, descensos, inflamaciones,* and/or *infecciones vaginales*, and reported by women as causing significant discomfort and worry, particularly because of the belief that it is a chronic illness that eventually ends in cervical cancer,

2) Complications in pregnancy and delivery, termed generally as *sufrimiento en el parto*, are considered important, especially by women in the rural highlands, because of the life and death situation in which many deliveries occur

3) Problems related to reproductive intentions, termed by women as *muchos hijos*, *muchos hijos muy seguidos*, and abortion are reported by women as important because of the toll on their bodies and on their socioeconomic status

Although the prioritized problems have been categorized by the project, it is important to note that women perceive the problems as integrally related For example, women reported that having "too many children too closely together" jeopardizes women's health and puts them at greater risk for complications during pregnancy and delivery Likewise, not complying with traditional birth practices and postpartum rest periods is believed to cause the discharge illness, which then puts women at risk for cervical cancer Interestingly, women related the vast majority of problems to contraception or a lack thereof, either by indicating that a family planning method caused a particular problem (such as discharge) or by reporting that use of contraception could prevent the problem from occurring

The *autodiagnóstico* results also demonstrate that various aspects of gender relations are important to women's reproductive health Domestic violence was reported by participants as a very frequent problem with severe consequences for their reproductive and general health, while abandonment by men, or the threat thereof, was also mentioned as negatively influencing women's reproductive health and quality of life Lack of confidence in and satisfaction with public-sector health services was reported in all *autodiagnósticos* and was named as a leading reason for which women do not seek care at those facilities

Once each CBO had chosen its priority reproductive health problem, the CBO was assisted by Manuela in the development of a subproject to address the problem's primary cause Once again, a participatory process was utilized to help CBO members identify and select causes and activities that were within both the CBO's comparative advantage and manageable interest Participants in the first 17 subproject designs identified lack of knowledge about their bodies as a major cause and consequently decided to undertake educational activities for themselves, their partners and women from their own and surrounding communities In some communities, these educational activities will be implemented in conjunction with other interventions, such as promotion of contraception and safe birthing practices It is anticipated that, over the life of the project, many of these first 17 CBOs will grow in their capacity to manage subproject activities and will carry out over time subprojects of increasing programmatic complexity and budgetary significance

In the project's income-generation component, the ReproSalud team has focused efforts on a pilot project to determine the best way to integrate microfinance and reproductive health interventions The pilot is comprised of two types of activities village banks and product development Thus far, Manuela has established 10 village banks in four districts which have achieved a rate of arrears of 0 percent Product development has had similar successes, with orders already having been made by local and international companies for handmade paper, brooms and dog leashes In March 1998, the experience of the pilot project will be analyzed, and Manuela and USAID will decide how best to scale up the integration of income-generation activities into the rest of the project

The advocacy component has already undertaken several campaigns associated with international days of commemoration For International Women's Day on March 8, 1996, project staff in regional offices conducted seminars on women's status, lack of access to family planning, domestic violence, and other problems in women's health For May 28, 1996, the International Day for Action in Women's Health, a poster aimed at promoting male responsibility in women's health was developed and distributed throughout the Ministry of Health's service delivery points A seminar on gender and women's reproductive health was also held for Ministry of Health personnel in Lima, with some 200 participants Another poster was printed and distributed nationally for November 25, 1996, the International Day Against Domestic Violence Recently, for the 1997 International Day for Action in Women's Health, Manuela worked with other women's groups to develop posters that advocate for high-quality accessible services The project has also actively participated in national and international conferences on reproductive health, gender and women's rights

Although many advocacy activities have been conducted since the project's initiation, USAID and Manuela would like for them to be carried out in the most strategic manner possible Thus, the Mission recently entered into an agreement with the Futures Group to have its Policy Project provide Manuela with technical assistance that includes formulating an advocacy strategy and assisting in its implementation The design of the strategy should begin in early 1998

Despite the inherent challenges in evaluating a large-scale, intersectoral, community-based project, progress has been made towards developing a monitoring and evaluation plan The logical framework created during the project's design by USAID was updated soon after the award by Manuela to incorporate that institution's strategies and perspectives At the project level, this framework includes indicators for measuring activities, outputs and objectives Indicators for measuring ReproSalud's goal, that of improving women's reproductive health in rural and peri-urban areas of Peru, are set at the level of the strategic objective and are principally measured through repeated demographic and health surveys

As part of its original proposal to USAID, Manuela proposed subcontracting out its monitoring and evaluation needs This was based on the desire for evaluation activities to be as objective as possible Thus, during the first months of the project, a scope of work was drafted, in preparation for a competition among Peruvian research institutions However, in late 1996 USAID and Manuela decided that an in-house approach to monitoring and evaluation was more appropriate, so plans were made to establish a monitoring and evaluation unit within the project infrastructure Since that establishment would take some time, a consultant was hired in the meanwhile to finalize the project's indicators, design and implement the baseline, and make recommendations on the organization and functioning of the monitoring and evaluation unit Recently, the head of that unit has been hired

To orient the consultant, USAID developed a conceptual framework that outlines the project's various assumptions, hypotheses and their implications for monitoring and evaluation (see Attachment) The consultant used that and other documentation to make progress in finalizing the indicators and in proposing an evaluation plan that depends essentially on baseline, midterm and final population-based surveys in communities selected to work with ReproSalud A pilot test of the baseline's survey instrument in one Aymara community was undertaken in July

The recently-hired director of monitoring and evaluation has strengthened the consultant's evaluation plan and is currently in the process of implementing the baseline studies in the initial 18 communities Field implementation of the baselines in the initial 18 communities was achieved in December 1997

Technical assistance is needed to advance further in this regard The current monitoring and evaluation design is currently based on a simple pre- and post- intervention design that is generally sufficient for the Mission's needs, keeping in mind that ReproSalud was not designed as a research project However, because of the innovative nature of the project and

the interest it has generated internationally, it behooves the Mission to ensure that the plan provide enough information and data to allow for more in-depth analysis Accordingly, the Mission is calling for technical assistance in higher levels of monitoring and evaluation

## II Purpose

The purpose of this technical assistance activity is to strengthen ReproSalud's monitoring and evaluation plan further to ensure the project's ability to meet the growing and demanding interest within the international population field for data on the feasibility, effectiveness, efficiency and replicability ReproSalud's approach In essence, in its short life and promising results to date, ReproSalud has generated a considerable amount of excitement and expectations, including a high level of burden of proof among observers knowledgeable in the population field As arguably one of the Agency's premier projects in implementing the Plan of Action of the 1994 Cairo Conference, ReproSalud is sparking a level of international interest that was unanticipated at the time of its design As a result, the Mission wishes to do everything possible to meet the expectations of analysts regarding ReproSalud's methodology, intersectoral approach, gender focus and other innovative and provocative aspects The technical assistance called for here will pay particular attention to the most innovative areas of the project because they are the most challenging to measure and because they offer information of particular interest to the international community Specific topics that may be of interest follow below

*a) Autodiagnóstico*

The autodiagnóstico is key to ReproSalud Its explicit purposes are to enable women to identify and prioritize their reproductive health problems, as well as to enable Manuela staff to have a better understanding of the perceptions of women in a specific community setting Achievement of these objectives is made possible by participatory techniques that are carried out over numerous three-hour sessions Originally the autodiagnóstico was composed of six of these sessions, but with a vision of reducing costs, it was reduced to five sessions Plans to reduce the number to four sessions are under consideration

Although initial experiences with the autodiagnostico indicate that the tool is effective and that the desired results are achieved, its innovative nature requires that it befurther examined The POPTECH team will examine ways to evaluate its general effectiveness, as well address concerns of cost and cost-effectiveness

*b) Working with Community-based Organizations*

ReproSalud's strategy is to reach rural and periurban women through existing women's community-based organizations (CBOs) This strategy is enabled by an infraestructure of mothers' clubs and milk clubs that came to exist in response to Peru's severe economic crises of the past few decades Originally, such organizations were born on their own, established

by individual women to facilitate their families' survival Later, the government built on these successful experiences, formally recognizing the organizations as implementors of state-run food programs and establishing similar organizations throughout the country The organizations were predominantly oriented towards survival, directing its actions at the day-to-day needs of their members and communities This survival orientation persists today

ReproSalud has taken advantage of this existing infraestructure to reach out to women in isolated parts of Peru Because the project originally contemplated the managerial and technical weaknesses that stem from CBOs' survival orientation and decade-long dependence on the government, long-term technical assistance was planned to ensure that their organizations' skills could be strengthened Manuela has served this function well, and indications thus far are that the strategy has been successful

Because this is perhaps the first time in Latin America that a large-scale effort has been made to work with grass-roots women's organizations, some have called for a further evaluation to determine the feasibility of similar strategies in other countries in Latin America and in other regions of the world However, others have indicated that working through women's grass-roots organizations is a strategy that has been utilized in other parts of the world and therefore is not in need of more in-depth evaluation Based on the consultants' experiences, a rapid survey of literature on the subject, and a canvassing of USAID/Washington's needs, the POPTECH team should determine whether this aspect of ReproSalud's design merits further evaluation, and if so, provide suggestions about how such an evaluation would be undertaken

*c) Self-identification and prioritization of problems*

Perhaps the key premise of ReproSalud is the notion that problems can be identified and prioritized from "below" while still accomplishing public health goals that have been established from "above " Thus, the project responds to women's most important felt needs, regardless of their ranking in public health terms If there is incongruency between the perceived need and public health, ReproSalud's hypothesis is that resolution of the perceived need increases the likelihood that a public health problem will eventually be seen as such and acted on by the community In other words, by first resolving problems of perceived importance, communities are more likely to accept public health problems and to direct resources towards resolving them

Some public health professionals have raised concern about this approach One of their reasons for concern stems from a belief that human beings are not likely to prioritize public health problems because of their more immediate call for curative care to satisfy personal health needs Individuals' ability to prioritize problems that are important to society as a whole is questioned Also questioned is the hypothesis that resolution of felt needs will lead eventually to the prioritization of public health problems

Preliminary data indicate that these concerns are not justified As indicated earlier, women

throughout Peru have identified three major problem areas vaginal discharge, complications during pregnancy and delivery, and problems relating to reproductive intentions (too many children and abortion) Two of these -- complications during pregnancy and delivery and too many children -- are certainly accepted as major public health problems Although vaginal discharge per se is not mentioned often as a public health problem, sexually transmitted infections are frequently acknowledged as causes of significant morbidity and mortality Thus, there is a a fair amount of congruence between public health priorities and women's priorities in reproductive health

Despite this relative congruence, further evaluation of the project's hypothesis regarding "felt needs versus real needs" is warranted POPTECH consultants should advise on ways to evaluate the validity of the hypothesis, including analyzing the degree of congruency that exists at project end between felt community needs and public health needs This advice may also include how to evaluate communities' decision-making process that results in congruency or lack thereof Of particular interest is whether working via women's perspectives and priorities results in increased and more effective use of contraception

*d) Bridging supply and demand*

Previous to ReproSalud's design, USAID/Peru's portfolio was comprised mostly of "supply-side" activities that focused principally on increasing the access to and quality of family planning services and other health interventions. This strategy was successful for many years, as demonstrated by increasing rates of contraceptive prevalence among women throughout Peru. Yet in the early 1990s, USAID/Peru and others in the country became increasingly concerned with an underutilization of family planning services in areas. Through site visits and research studies in areas where access was not a problem, it became evident that other factors were negatively influencing communities' ability or desire to use services. Among the most important were gender -- particularly issues related to women's relationships with their partners -- and quality of care concerns. ReproSalud was designed to address these "demand-side" issues and to serve as a cultural broker between the community and health services.

Demand-only approaches are not unique in the international family planning field. Mass media campaigns have been used effectively in a number of ways, for example, in increasing awareness and knowledge of family planning methods and promoting the social acceptance of family planning. Although ReproSalud does not preclude the possibility of mass media approaches, it has a more grass-roots orientation that enables reflection and action at both the individual and community level. Such an approach to demand generation is less common in the international family planning field, although the Cairo Plan of Action recently proposed that similar strategies be better incorporated into the population community's repertoire of activities.

Thus, the innovative nature of ReproSalud's demand generation approach warrants further evaluation. POPTECH consultants will work to determine the best way to evaluate the



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approach. They may choose specific components of the approach (autodiagnosis, popular education activities, etc.) to include in the evaluation.

*e) Women's Empowerment*

Women's empowerment is a central organizing principle of ReproSalud The sub-goal of addressing women's strategic gender needs is aimed at addressing impediments to women's ability to overcome situations of subordination in given socio-cultural contexts The underlying hypothesis is that by addressing those impediments, women can more readily become empowered

Typically, such impediments have not been addressed in health programs because these have tended to focus on meeting women's practical needs, *i e* , those related to their roles as mothers and caretakers ReproSalud does not discard this approach -- it builds on it by incorporating programmatic interventions that enable women to develop or further strengthen other roles aside from their childbearing and childrearing reponsibilities This is sought by strengthening women's negotiation and decision-making skills within the family unit and the community by offering alternative roles outside the family unit Also under development is a plan to conduct outreach with men to encourage greater support for family planning use, sharing of routine household burdens and increased caretaking responsibility for children Such actions would address women's needs by reducing the burden of their reproductive roles

Thus, ReproSalud may offer a rare opportunity to evaluate women's empowerment in the context of a reproductive health project being carried out in diverse cultural and geographic settings Because of the project's holistic approach, such an evaluation may have to distinguish from effects that emanate solely from the community-based reproductive health approach and those that stem from the inclusion of the microcredit component To meet the varying needs of different analysts, data on the several interactions and aspects may have to be teased out separately

*f) Impact of Microcredit Activities on Contraceptive Use and Other Reproductive Health Interventions*

Microcredit activities have long been held as an important avenue for women to increase their income and control over resources Evaluations of microcredit activities, particularly communal approaches such as village banking, have generally demonstrated that such programs are able to increase women's control over resources and concomitantly improve the balance of power between women and their male counterparts Analyst have hypothesized about the corollary effects that such changes in power may bring about, including improved health status for women and their children

In recent years, the discussion of possible corollary effects on health status has narrowed even more specifically to effects on contraceptive use A team of researchers led by Dr Sid

Schuler investigated contraceptive use among Bangladeshi women who participated in microcredit programs, including those run by the Grameen Bank and the Bangladesh Rural Action Committee (BRAC) Increasingly evident is a positive association between women's participation in microcredit programs and contraceptive use, however, methodological problems make it difficult to assess the degree, if any, of causality

Again, ReproSalud may offer a rare opportunity to assess this causality because it may be feasible to gather longitudinal data on women who participate in the reproductive health component and those who participate simultaneously in both the reproductive health and microcredit components It may be that there are both direct and indirect effects of microcredit on contraceptive use, but whether these can be teased out in an evaluation remains to be determined

*g) Channeling women's concerns via advocacy*

ReproSalud's approach of working at the community level enables it to delve into many of the "micro" issues that affect use of contraception and other reproductive health interventions However, working at the micro level alone does not address structural impediments effectively because they are beyond the control of individual communities The advocacy component was designed to address this potential deficit of working only at the micro level It was also hoped that the component would enable women to voice their reproductive health concerns to authorities and to demand that authorities respond with adequate resources and policies

Although working in policy is not new to the population field, the "bottom-up" approach of advocacy is less chartered Thus, ReproSalud offers a good opportunity to evaluate advocacy activities and their impact on reproductive health programs POPTECH's team could provide advice on how to evaluate this bottom-up policy approach within the context of the ReproSalud project The team should note that, as indicated earlier, the services of the Policy project were acquired recently to assist Manuela in the design and implementation of an advocacy strategy This strategy includes the identification of indicators and an evaluation plan It is hoped that much of the strategy's design will be completed by the time of the POPTECH's team arrival in Peru and that this will facilitate the team's work

## III Description of activities

Taking the above into consideration, the technical assistance acquired through this scope of work should carry out activities that further develop the project's ability to monitor and evaluate its most innovative aspects, such as those listed above Activities most likely will include, but not be limited to, the following

a) Review the project paper, conceptual framework on monitoring and evaluation, quarterly reports, annual reports, and other documentation to get an understanding of the project's goals, objectives, and current implementation

strategies

b) Identify the data needs and interests of specific audiences within the international population field, including, but not limited to, USAID/W (Center for Population, Health and Nutrition, PPC, and the LAC regional bureau), researchers involved in following up implementation of the Cairo Plan of Action, and key women's health advocates

c) Based on the data needs identified, formulate hypotheses warranting testing

d) Conduct a review of literature relevant to these hypotheses, with particular attention to methodology, indicators, and cost factors

e) Conduct interviews with project staff to get a richer understanding of the project's operations and implementation

f) Review the monitoring and evaluation activities conducted and planned thus far and assess to what extent it will be able to answer the data needs identified

g) Assess the monitoring and evaluation skills of Manuela's ReproSalud staff

h) In a final report, make recommendations to improve the monitoring and evaluation strategy, particularly in the areas of indicators, evaluation design, data analysis and training Minimally, the final report should be composed of the following

- a plan that describes the design of the project's evaluation and how it will be implemented, including a description of how the data generated thus far will be utilized,
- new and/or improved evaluation instruments, including a plan for their pretesting and modification,
- recommendations for any additional technical assistance or training that Manuela may need

## III Personnel

*a) Level of Effort*

Depending on their skills and language abilities, a team of two or three research and evaluation specialists might be contracted All team members should be able to communicate adequately in Spanish with the staff of Movimiento Manuela Ramos

Two senior-level researchers are called for, each should have at least 10 years of experience in the fields of women's empowerment, reproductive health and/or microfinance Assuming that two such professionals who also speak Spanish can be found, the total level of effort

would be 12 person weeks If one senior-level researcher does not speak Spanish fluently, it will be necessary for a junior or mid-level researcher with strong language skills to accompany the team, thereby raising the estimated level of effort to 18 person weeks The time would be broken down as follows

Week 1-2 In the US Team consolidation, clarification of objectives, division of work, introduction to project via project documentation, literature review, informational interviews, further understanding of project

Week 3-5 In Perú Travel to Lima for briefings with Mission and Movimiento Manuela Ramos, revision of more documentation and baseline data, travel to 2 or 3 project sites, reflection, brainstorming, development of preliminary recommendations and report, debriefing with counterparts

Week 6 In the US Further development of recommendations and finalization of report

*b) Technical Qualifications*

Emphasis will be placed on the ability of the consultants to work as a team and to complement each other's skills, management styles and conceptual abilities In its totality the team should possess the following qualifications

- Training in sociology, demography, public health, political science, economics, anthroplogy or a related social science at the Ph D level,
- A minimum of 20 years of experience in the design and implementation of quantitative evaluations in reproductive health, Women in Development (WID), and/or microenterprise and credit programs, preferably in Latin America,
- Knowledge of and demonstrated ability to apply gender theory,
- Knowledge of and demonstrated ability in both qualitative and quantitative reserach,
- **Proven** ability to communicate highly proficiently in Spanish Evidence must be provided of an individual's language capability,
- Demonstrated ability to work collegially within a team environment,
- Availability for at least 3 weeks in Peru Since travel to jungle and high-altitude (up to 14,000 feet) areas will be required, candidates must meet relevant health requirements



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The Mission reserves approval rights of the team



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**ReproSalud**

*Conceptual Framework for Project Evaluation*

Goal To improve reproductive health among women in rural and peri-urban areas

Sub-goal To address the strategic gender needs of women

Purpose
To increase the use of family planning and other selected reproductive health interventions mentioned in Hypothesis 1, supported by community-based programs

Effects at the purpose level are the measure of success

**Underlying Assumptions**

*Assumption 1* The move from the desire to control fertility to the use of contraception is not automatic It is mediated by political, economic, social and cultural factors, among others

*Assumption 2* Supply alone does not determine use of conventional reproductive health services[1] for all women For many women, other factors intervene, such as gender relations, familial and community social norms, cultural codes and inter-class relations Many of these factors are embedded in power relations between sexes, between ethnic groups, between social classes and other forms of social organization

*Assumption 3* Women who are in this category can be referred to as hard-to-reach women These women are ReproSalud's primary target group Hard-to-reach women are often at a disadvantage in power relations

Assumption 4 Notwithstanding the mediating factors, hard-to-reach women are concerned about their reproductive health, and they desire to improve it

*Assumption 5* One form of social organization is the community-based organization, in which women join together to work collectively toward a common goal This type of organization can facilitate reflection and provide impetus for action

*Assumption 6* By accompanying women members of a community-based organization through an exercise in self-reflection and analysis of community factors that affect their
reproductive health *(i e , the autodiagnostico)*, hard-to-reach women can identify and prioritize their reproductive health needs

*Assumption 7* If we work from the self-identified felt needs of hard-to-reach women in ways that involve them, they will increase their knowledge of reproductive health

*Assumption 8* The self-reflection, analysis of community factors and increased knowledge of reproductive health will help empower women to demand the health services they desire

---

[1] Conventional Reproductive health services means health post centers hospitals and other service delivery points of the public and private sect

*Assumption 9* If health services listen to women's demands, they can adapt their services to make them more acceptable to hard-to-reach women

*Assumption 10* The combination of improved, more women-centered services and empowered women will translate into an increased use of conventional health services by hard-to-reach women

*Assumption 11* Increased use of health services will translate into improved reproductive health status, including heightened use of contraception

*Assumption 12* Women's empowerment can also be promoted by increasing the control women have over financial resources Two interrelated ways to do this are to give women access to credit and to enable them to generate income

*Assumption 13* At an aggregate level, income is positively associated with contraceptive prevalence and other reproductive health indicators

*Assumption 14* At a programmatic level, heightened control over financial resources can be positively associated with contraceptive prevalence and other reproductive health indicators Hypothesized pathways for possible causality in this respect are that increased income facilitates access to health services, opens up options to women other than childbearing and rearing, and/or empowers them to negotiate sex and use of contraception with their partner in a more forceful way

*Assumption 15* Women's empowerment can result in more equitable gender relations, as indicated by strengthened skills in negotiating with husbands or partners, decreased incidence of domestic violence, greater decision-making roles for women within family units, and more or more important leadership roles for women in the community

*Assumption 16* We can also promote more equitable gender relations by working with the spouses and partners of hard-to-reach women This work should center on reducing the spousal, familial and community barriers to use of health services, to improved reproductive health and to enhanced family and community roles for women In spousal relations, it should seek to mitigate the causal factors of domestic violence

**Hypotheses**

*Hypothesis 1* Women who experience the programmatic sequence[2] of ReproSalud will make greater use of reproductive health services than they did before that experience

Among other indicators, this greater use of reproductive health services will be reflected by

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[2] Programmatic sequence refers to participation through a community-based organization in the competition for support under ReproSalud autodiagnostic sub-project design and sub-project implementation in reproductive health

2 Programmatic sequence refers to participation through a community-based organization in the competition for support under ReproSalud autodiagnostico sub-project design and sub-project implementation in reproductive health

a higher contraceptive prevalence rates
b lower discontinuation rates (i e , more effective use of contraception)
c longer closed and open birth intervals
d a lower proportion of women with undesired pregnancies

Greater use will also be reflected by

e longer average duration of exclusive breastfeeding
f a greater proportion of women who receive prenatal care
g a greater proportion of women who receive postnatal care
h a lower prevalence of reproductive tract infections
i a lower prevalence of iron deficiency anemia
j a higher proportion of births attended by trained personnel

*Hypothesis 2* Women who experience the programmatic sequence of ReproSalud and participate in the project's economic activities (i e , income-generation and/or village banking) will make greater use of reproductive health services, as defined above, than women who solely experience the programmatic sequence

*Hypothesis 3* Women who participate in ReproSalud in any of the two ways outlined above will achieve more equitable gender relations with their spouse or partner, within their larger family unit and within the community

**Evaluation implications**

*Implication 1* Three levels of evaluation are called for

a Sub-project level Evaluation here will measure the achievements of each subproject Evaluation will center on the monitoring and evaluation indicators called for in the sub-project proposals Key measurement here will be on educational achievement, as measured by pre- and post-tests of participants All sub-projects must have evaluation indicators aside from such process ones as number of participants

b Project level Evaluation here will consist of the baseline survey and the final impact evaluation

Various instruments are proposed

i Baseline and final surveys on reproductive health among a random sample of women aged 15-49 in the catchment area of the participating community-based organization

ii Baseline and final surveys on reproductive health among a random sample of men aged 15-59 in the catchment area of the participating community-based organization

iii Baseline and final surveys on credit and income among a random sample of men and women of the same age in the same area

2 Programmatic sequence refers to participation through a community-based organization in the competition or support under Reprosalud autodiagnostico sub-project design and sub pro ect implementation in reproductive health

iv Baseline and final surveys on participation among a random sample of women of the same age in the same area

v Baseline and final profiles of the catchment area of the participating community-based organization

c Aggregate level The 1996 ENDES serves as an aggregate baseline, while the 2001 ENDES serves as an aggregate impact evaluation, to which ReproSalud will have contributed Within the ENDES, the evaluation unit should find out what ReproSalud districts are in the 1996 ENDES sample This can provide fertility indicators and other data requiring wider population samples ReproSalud can then finance an over-sample of the 2001 ENDES that can provide time-series data for this group of indicators

*Implication 2* The catchment area needs to be defined Possibilities are the subdistrict level or the district level

*Implication 3* two categories

Intervention areas and/or women participants need to be separated into

a Programmatic sequence alone
b Programmatic sequence plus economic activities

*Implication 4* this document

Baseline surveys need to measure all the impact indicators identified in

a This includes anemia testing the equipment to do this INEI/MACRO should be able to help furnish the equipment to do this

b This also includes testing for reproductive tract infections The study being coordinated by Garcia and Chavez should be designed to cover this need

*Implication 5* Baseline surveys need also to measure some knowledge and process indicators that should lead to the impact indicators These should include data on women's opinions of conventional health services

*Implication 6* Sub-projects need to measure knowledge and process indicators specific to the activity at hand

*Implication 7* Empowerment indicators need to specified and measured They should relate to more equitable gender relations with the woman's spouse or partner (including incidence of domestic violence), within her larger family unit, and within her community

*Implication 8* The use of controls is not considered feasible on two accounts

a Impact/multiplier effect ReproSalud seeks to have an effect beyond the specific community-based organizations selected for the original contact This makes it difficult to select control areas with similar characteristics to the intervention area

2 Programmatic sequence refers to participation through a community-based organization in the competition for support under Reprosalud autodiagnostico sub-project design and sub-project implementation in reproductive health



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b History Even if the evaluation plan were to call for identifying control districts removed from the original intervention areas, the multiple actions in reproductive health -- and particularly family planning -- that are being undertaken throughout the country do not make identification of uncontaminated control areas likely Further, ethical considerations argue against limiting ReproSalud's possible effects artificially

Accordingly, time-series data at the three levels of evaluation will be the measures of impact

*Implication 9* Two other aspects of the project that warrant evaluation are

a The *autodiagnostico* as the tool that catalyzes self-reflection and analysis The research question would be Is the *autodiagnostico* a feasible, necessary and effective tool for initiating meaningful activities with hard-to-reach women?

b The community-based organization as the unit of action The research question would be Is the community-based organization a feasible, necessary and effective mechanism for promoting reproductive health among hard-to-reach women?

This might be done through case studies and/or panel studies (A panel study tracks particular individuals over time ) Through case studies and panel studies, we can better trace the impact of the project on women's lives

Monitoring

*Point 1* Monitoring should be designed to

a Support the conceptual flamework for evaluation

b Provide information on progress through qualitative data *(e g ,* quotes from women) and process indicators

c Allow for timely reporting on progress

d Enable identification of bottlenecks in implementation and other problems that might call for mid-course corrections

*Point 2* Among suggested monitoring indicators

a Number of project cycles underway
b Number of project cycles completed
c Number of project presentations made
d Number of community-based organizations that have registered to participate
e Number of community-based organizations that have been selected to participate
f The number of members belonging to the organizations selected
g Number of *autodiagnosticos* completed

2 Programmatic sequence refers to participation through a community-based organization in the competition for support under ReproSalud autodiagnostico sub-project design and sub-project implementation in reproductive health

h A breakdown, by frequency, of the priority problems identified
i Number of sub-projects developed
j Number of sub-projects in implementation
k Number of beneficiaries of that implementation
l Number of sub-projects completed
m Number of beneficiaries of the completed sub-projects
n Effects of the sub-projects -- both quantitative and qualitative For example
  -- breakdown of participants by sex
  -- results of pre- and post-tests
  -- case studies (quotes) from participants
  -- changes in attitude or other changes that result, including changes in local health services
  -- follow-on activities

*SKBrems, BFeringa and ReproSalud counterparts, 7/18/97*

2 Programmatic sequence refers to participation through a community-based organization in the competition for support under ReproSalud autodiagnostico sub-project design and sub-project implementation in reproductive health

# APPENDIX B

## Bibliography


Abramson, J. H. *Making Sense of Data: A Self-Instruction Manual on the Interpretation of Epidemiologic Data*. New York: Oxford University Press, 1994.

Alberti, A. "Gender, Ethnicity, and Resource Control in the Andean Highlands of Ecuador." Ph.D. dissertation, Stanford University, 1986.

Bardales, A. "Muestra." (N.D.).

Brems, S; B. Feringa; and ReproSalud Counterparts. "Conceptual Framework for Project Evaluation." 18 July 1997.

Cochran, W. *Sampling Techniques*. New York: Wiley and Sons, 1963.

Coe, A. B. "Women's Empowerment Through Community-Based Reproductive Health Programs: A Case Study in Peru." Master's thesis, The American University, Forthcoming.
Feringa, B. "Comments on Scope of Work for POPTECH Team." 3 March 1997.

Foreit, J. Memo to Barbara Feringa and M. Garate. 1 October 1996.

Garcia, P. *Informe de resultados del projecto descenso vaginal en mujeres de zonas rurales*. 13 February 1998.

Hashemi, S. M., and S. R. Schuler. "Defining and Studying Empowerment of Women: A Research Note From Bangladesh." John Snow International Working Paper No. 3, 1993.

Hashemi, S. M.; S. R. Schuler; and A. Riley. "Rural Credit Programs and Women's Empowerment in Bangladesh." *World Development* 24 (1996): 635–663.

Huntington, D., and R. S. Schuler. "A Review of the Simulated Client Methodology for Evaluating Client-Provider Interactions in Family Planning Clinics." *Studies in Family Planning* 24, no. 3, 1993.

Instituto Nacional de Estadistica e Informatica. *Huancavelica Poblacion, Mujer y Salud: Resultados de la encuesta demografica y de salud familiar 1996*. Lima: 1997.

Instituto Nacional de Estadistica e Informatica. *Ucayali Poblacion, Mujer y Salud: Resultados de la encuesta demografica y de salud familiar 1996*. Lima: 1997.

Population Council. “Men as Partners in Health Project.” Response to USAID/Peru’s RFQ 97–006, 1997.

Posner, J., and D. Vandell. “Low-Income Children’s After-School Care: Are There Beneficial Effects of After-School Programs? *Child Development* 65 (1994): 440–56.

ReproSalud. *Informe de Evaluación Anual Plan Operativo 1996*. 1997.

Rogow, D. and S. Wood, Trip Report. 23 December 1997.

Schuler, S. R.; M. E. Choque; and S. Rance. “Misinformation, Mistrust, and Mistreatment: Family Planning Among Bolivian Market Women.” *Studies in Family Planning* 25 (1997): 211–221.

Schuler, S. R.; and S. M. Hashemi. “Credit Programs, Women’s Empowerment, and Contraceptive Use in Rural Bangladesh.” *Studies in Family Planning* 25 (1994): 65–76.

Schuler, S. R.; S. M. Hashemi; and S. H. Badal. “Men’s Violence Against Women in Rural Bangladesh: Undermined or Exacerbated by Microcredit Programs?” *Development in Practice/Oxfam*. Forthcoming May 1998.

Schuler, S. R.; S. M. Hashemi; and A. Riley. “The Influence of Changing Roles and Status in Bangladesh’s Fertility Transition: Evidence From a Study of Credit Programs and Contraceptive Use. *World Development* 25, no. 4, 1997.

Schuler, S. R., and Z. Hossain. “Family Planning Clinics Through Women’s Eyes and Voices: A Case Study From Rural Bangladesh.” *International Family Planning Perspectives*. Forthcoming.

Schuler, S. R.; E. N. McIntosh; M. C. Goldstein; and B. R. Pande. “Barriers to the Effective Use of Family Planning Services in Kathmandu.” *Studies in Family Planning* 16, no.5, 1985.

Unidad Tecnica. “*Guia del Autodiagnóstico*.” Movimiento Manuela Ramos, l997.

## APPENDIX C

## List of Contacts

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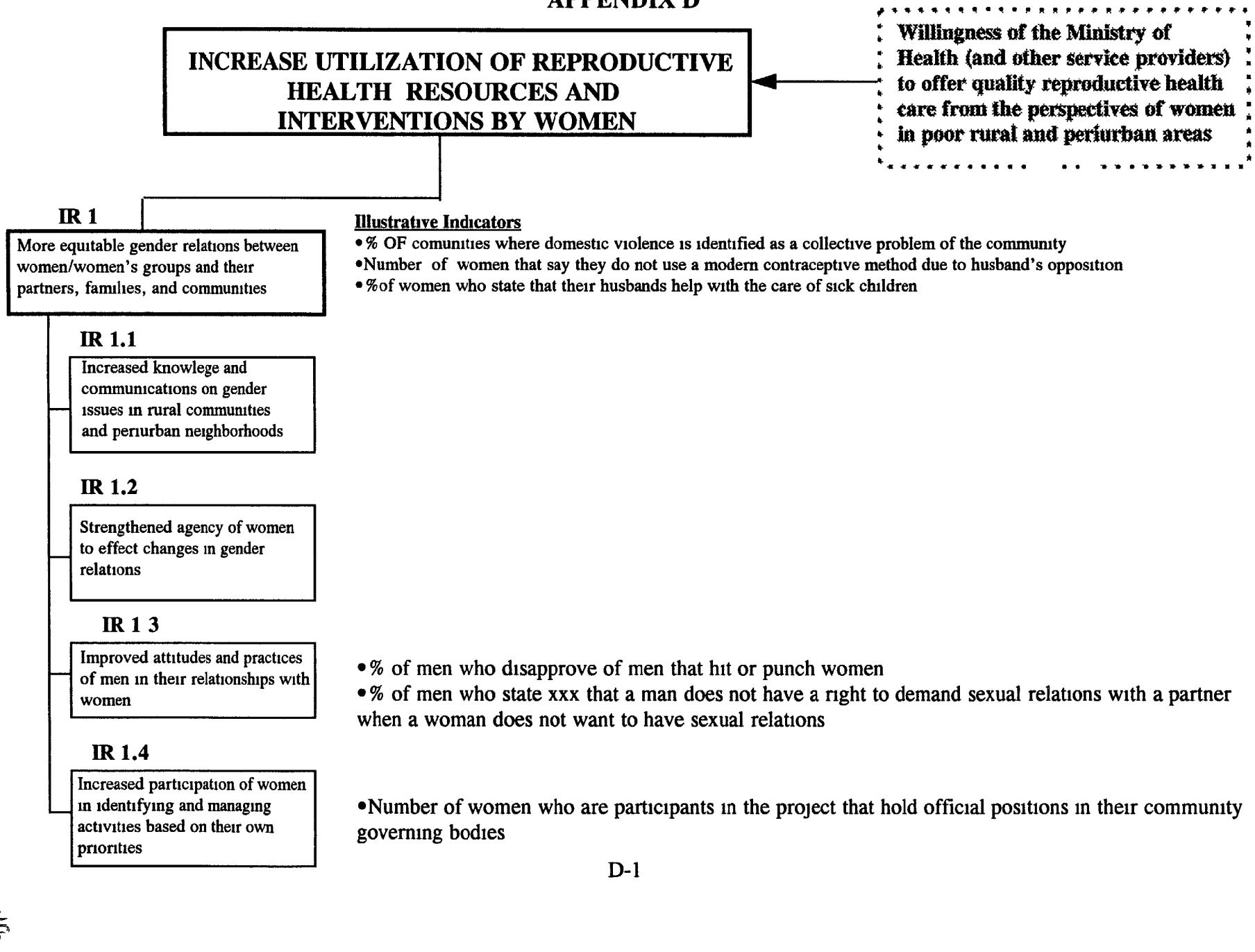
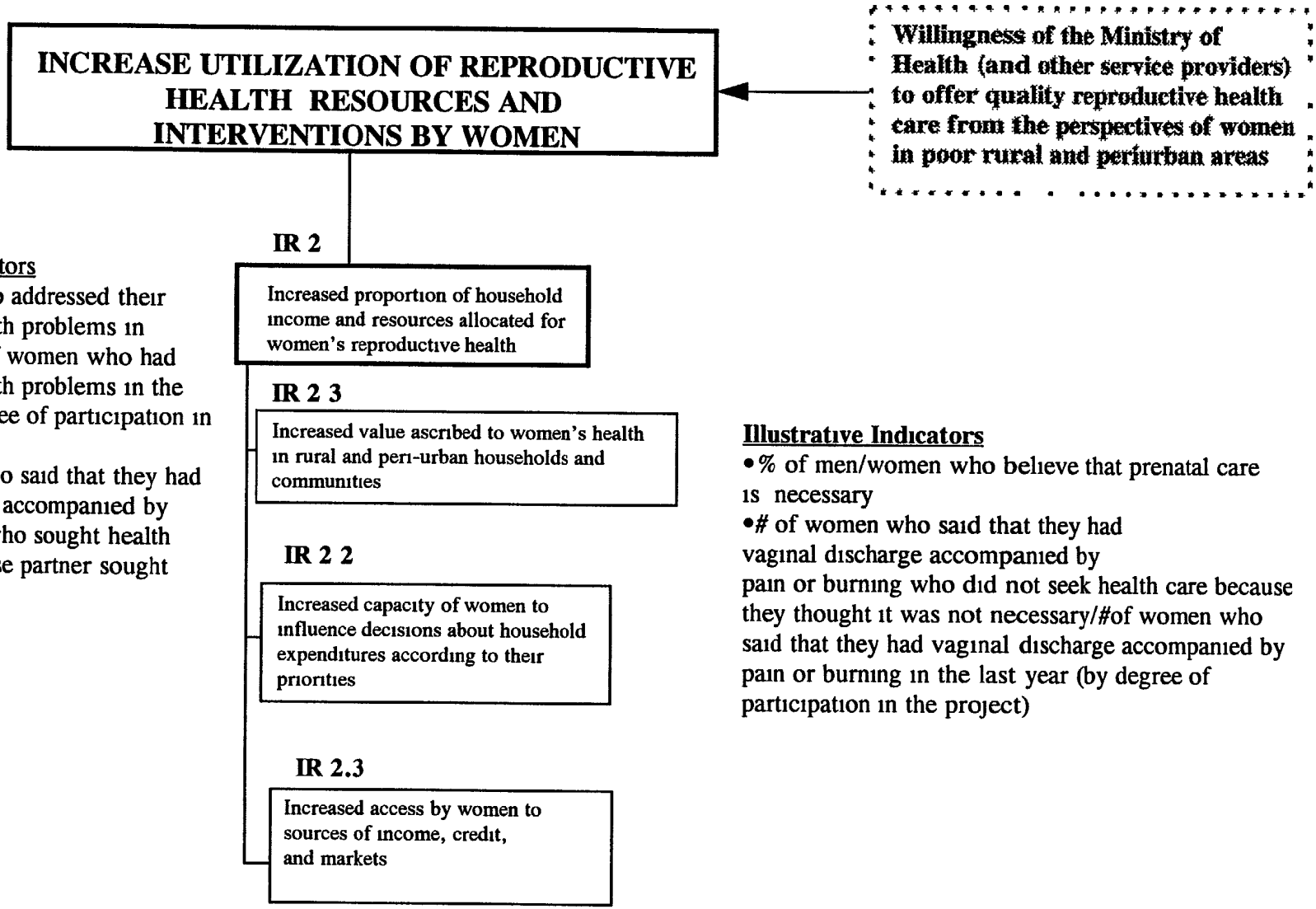
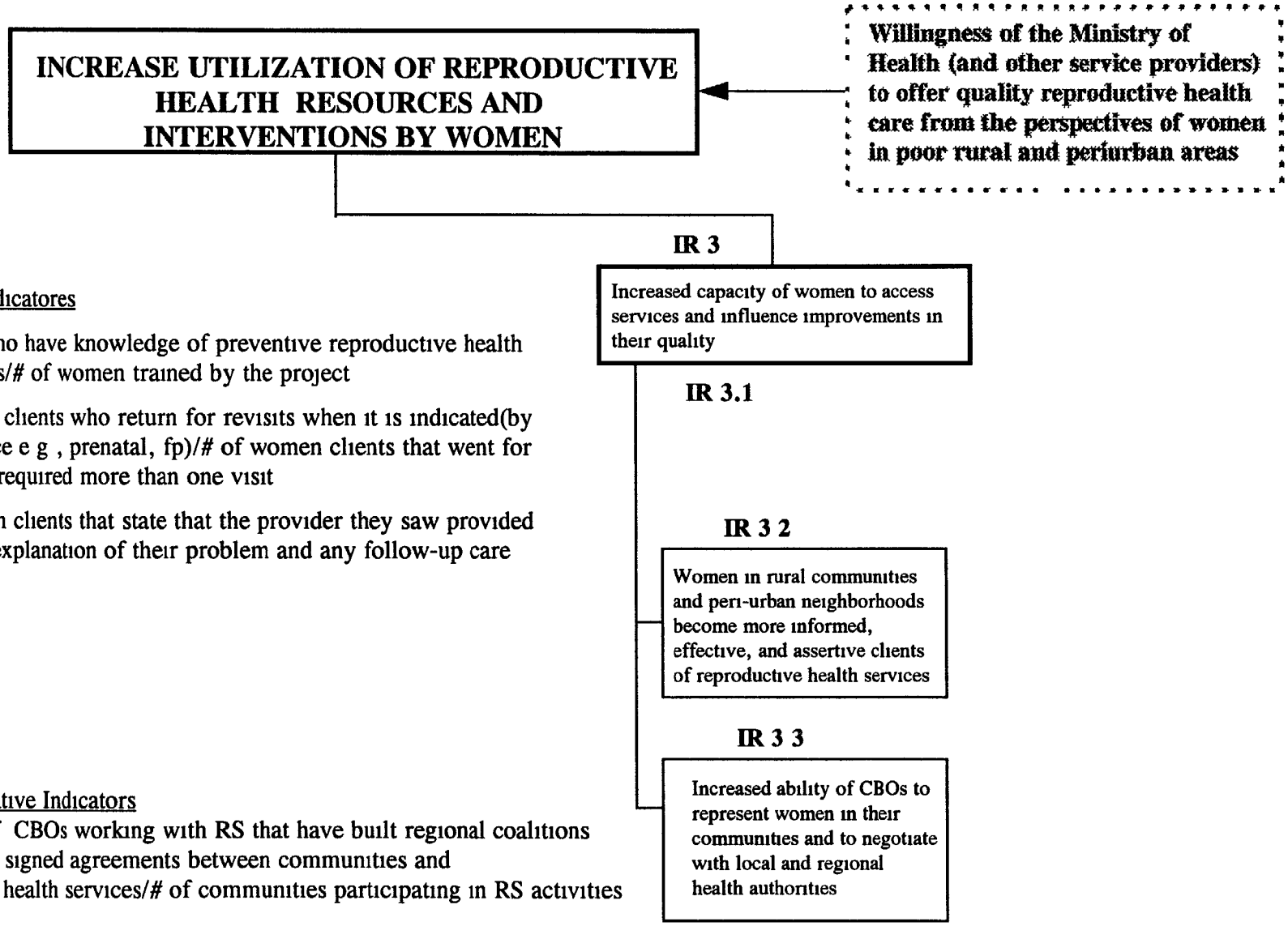
## APPENDIX D


INCREASE UTILIZATION OF REPRODUCTIVE HEALTH RESOURCES AND INTERVENTIONS BY WOMEN
Willingness of the Ministry of Health (and other service providers) to offer quality reproductive health care from the perspectives of women in poor rural and periurban areas
IR 1
More equitable gender relations between women/women's groups and their partners, families, and communities
Illustrative Indicators
• % OF comunities where domestic violence is identified as a collective problem of the community
•Number of women that say they do not use a modern contraceptive method due to husband's opposition
• %of women who state that their husbands help with the care of sick children
IR 1.1
Increased knowlege and communications on gender issues in rural communities and periurban neighborhoods
IR 1.2
Strengthened agency of women to effect changes in gender relations
IR 1 3
Improved attitudes and practices of men in their relationships with women
• % of men who disapprove of men that hit or punch women
• % of men who state xxx that a man does not have a right to demand sexual relations with a partner when a woman does not want to have sexual relations
IR 1.4
Increased participation of women in identifying and managing activities based on their own priorities
•Number of women who are participants in the project that hold official positions in their community governing bodies


INCREASE UTILIZATION OF REPRODUCTIVE HEALTH RESOURCES AND INTERVENTIONS BY WOMEN
Willingness of the Ministry of Health (and other service providers) to offer quality reproductive health care from the perspectives of women in poor rural and periurban areas
IR 2
Increased proportion of household income and resources allocated for women's reproductive health
IR 2 3
Increased value ascribed to women's health in rural and peri-urban households and communities
IR 2 2
Increased capacity of women to influence decisions about household expenditures according to their priorities
IR 2.3
Increased access by women to sources of income, credit, and markets
Illustrative Indicators
•# of women who addressed their reproductive health problems in the last year /# of women who had reproductive health problems in the last year (by degree of participation in project activities)
•% of women who said that they had vaginal discharge accompanied by pain or burning who sought health services and whose partner sought health services
Illustrative Indicators
•% of men/women who believe that prenatal care is necessary
•# of women who said that they had vaginal discharge accompanied by pain or burning who did not seek health care because they thought it was not necessary/#of women who said that they had vaginal discharge accompanied by pain or burning in the last year (by degree of participation in the project)




Illustrative Indicatores

•# women who have knowledge of preventive reproductive health care measures/# of women trained by the project

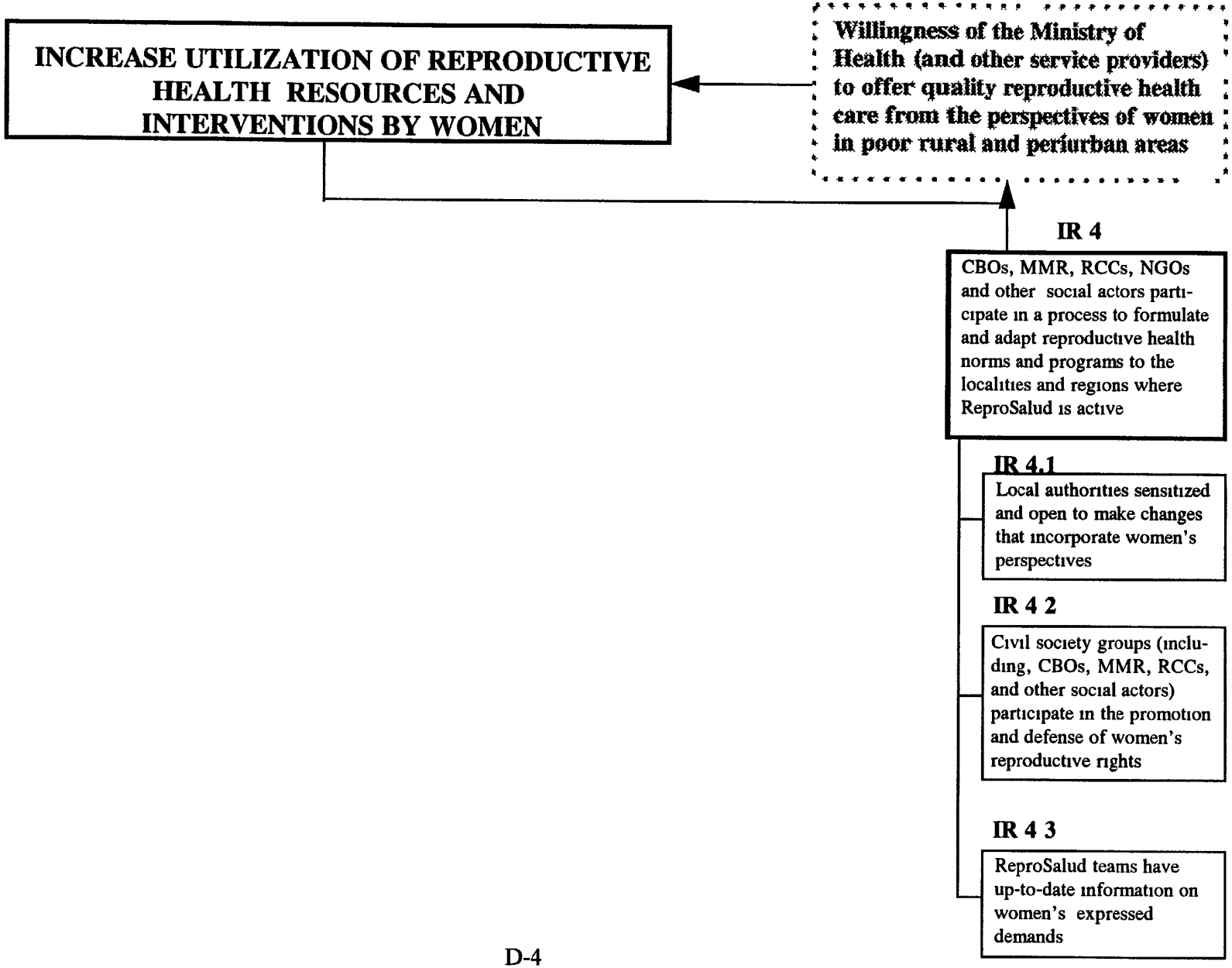
•# of women clients who return for revisits when it is indicated(by type of service e g , prenatal, fp)/# of women clients that went for services that required more than one visit

•% of women clients that state that the provider they saw provided an adequate explanation of their problem and any follow-up care

Illustrative Indicators

•% of CBOs working with RS that have built regional coalitions

•# of signed agreements between communities and MOH health services/# of communities participating in RS activities


INCREASE UTILIZATION OF REPRODUCTIVE HEALTH RESOURCES AND INTERVENTIONS BY WOMEN
Willingness of the Ministry of Health (and other service providers) to offer quality reproductive health care from the perspectives of women in poor rural and periurban areas
IR 4
CBOs, MMR, RCCs, NGOs and other social actors participate in a process to formulate and adapt reproductive health norms and programs to the localities and regions where ReproSalud is active
IR 4.1
Local authorities sensitized and open to make changes that incorporate women's perspectives
IR 4 2
Civil society groups (including, CBOs, MMR, RCCs, and other social actors) participate in the promotion and defense of women's reproductive rights
IR 4 3
ReproSalud teams have up-to-date information on women's expressed demands

## APPENDIX E

### Independent Variables: Degrees and Types of Participation

Community-based organizations are ReproSalud's vehicle of entry into the local communities. They are preexisting organizations with defined positions of leadership that have functioned in the local communities for a minimum of two years. Most of the CBOs selected, however, have been operating for considerably longer than that, many having been formed in the early 1980's. For ReproSalud's purposes, they must also be CBOs of women in either periurban or rural areas. Given the historical context of Peru during this period, nearly all existing CBOs of women in the project areas are organizations that were formed to channel subsistence aid into the local communities.

The initial series of ReproSalud activities at the community level—presentation of the sociodrama, the *autodiagnóstico*, and the design of the subproject—all draw exclusively on members of the CBO. However, depending on the size of the CBO, all members may not participate in these initial activities. The *autodiagnóstico*, for example, is generally limited to about 20 participants, although many of the participating CBOs have 40 to 50 members. In those cases where the number of CBO members exceeds the number of persons who are invited to participate in the activity, the CBO members themselves select those members who will actually participate. The subproject design activity is also limited to about 20 participants. These participants are often, but not always, only those women who have participated in the *autodiagnóstico*.

The point at which the CBO is no longer the exclusive source of participants occurs at the time of the preparation for the replication activities, which are part of the product of the subproject design activity. The subproject design—independent of its content—needs to include a plan of outreach to neighboring barrios or communities or concentrated areas of focus within the community. To achieve this end, individuals are nominated as potential candidates for the position of local promoters who will conduct the outreach replication activities. The persons nominated as candidates for promoters generally include members of the original CBO, as well as persons who are not. Depending on the content of the subproject, in some cases men are also nominated as candidates for promoters. The promoter nominees then receive training from the ReproSalud regional staff, knowing beforehand that only half of them will actually be named promoters at this time. It is then the responsibility of these new promoters to organize the outreach activities in their designated areas, either through affiliate CBOs, or through subgroups of the collaborating CBO if its geographical extension is very large.

For some women, participating in these outreach replication activities represents their first contact with ReproSalud even though they are members of the collaborating CBO. In addition, three pilot districts are providing microfinancing and product development options to qualifying CBO members. In the case of those women who become members of the village banks or producers of

products to be channeled through the production of products and marketing component of ReproSalud that experience may consititute their first contact with ReproSalud.

Given this variation in how and in which activities members and non-members of the collaborating CBOs participate, there is an obvious need to differentiate degrees and types of participation at the individual level to explore relationships between ReproSalud's activities and desired project outcomes.

At present, there are only two questions in the baseline study that permit any differentiation according to participation among persons interviewed at the community level. One question, number 4, asks whether the woman is a member of the CBO. The other, question number 511, asks whether she is a member of a communal bank. As the preceding description illustrates, women who are CBO members may participate very differently from one another in ReproSalud activities. In larger CBOs, members may not be actual participants until the replication activities, while women who are not CBO members may also participate in select ReproSalud activities such as the replications. Further, women who are CBO members may have their access to sources of income generation, credit, and markets increased via ReproSalud through means other than membership in a communal bank, while others do not have that option at all.

To address these issues of membership versus participation and provide for a more differentiated analysis of the factors associated with changes in behavior, we propose the creation of a series of independent variables. A description of four such independent variables follows.

**Involvement of Women in ReproSalud's Programmatic Sequence**

The three main hypotheses of the ReproSalud project presented in the original conceptual framework postulate a positive relationship between degree of participation in what is referred to as the "programmatic sequence" of ReproSalud and select outcomes promoted by the project. To explore these hypothesized relationships, each person's type and degree of involvement or participation in the ReproSalud activities needs to be calculated. For women, a variable that captures this participation could be called ***degree* of woman's involvement in ReproSalud activities *(MUPARGEN: Participación de la mujer en actividades generales)***. For this and all other proposed independent variables, the value assigned for each instance is arbitrary and could be weighted differently.

| Type of Involvement (Steps in Programmatic Sequence) | Value Assigned | Actual Participation Score |
|---|---|---|
| CBO member | 1 | |
| Member of the Board | 1 | |
| Participant in the *autodiagnóstico* | 2 | |
| Participant for planning of subproject #1 | 1 | |
| • Member of core unit | 1 | |
| • Potential health promoter | 1 | |
| • Selected health promotor | 2 | |
| • Participant in training/replication activities | 1 | |
| Participant for planning of subproject #2 | 1 | |
| • Member of core unit | 1 | |
| • Potential health promoter | 1 | |
| • Selected health promotor | 2 | |
| • Participant in training/replication activities | 1 | |
| Participant for planning of subproject #3 | 1 | |
| • Member of core unit | 1 | |
| • Potential health promoter | 1 | |
| • Selected health promotor | 2 | |
| • Participant in training/replication activities | 1 | |
| Etcetera | | |
| **Total Points for Woman's General Involvement** | | |

A score for the degree of woman's involvement in ReproSalud activities should be calculated at the time of the interview for each female household member interviewed for the baseline. The score should be recalculated each time the baseline survey questionnaire (as a repeated measure), or a similar monitoring instrument, is administered. It should be kept in mind that whether the planned investigation is qualitative or quantitative, the individuals' differentiation along these lines should be considered.

**Increased Access to Economic Resources through ReproSalud**

The conceptual framework also posits a relationship between the variable **degree of woman's involvement in ReproSalud activities *(MUPARGEN: Participación de la mujer en activitidades generales)***, described above, and a variable that could be called **degree of woman's**

**access to economic resources** ***(MUACSECO: Aceso de la mujer a recursos económicos***). In this variable it is important to allow for the possibility that women may already have access to economic resources although that access may be enhanced through ReproSalud's associated economic activities. As with the other participation/involvement variables presented, the assigned values are arbitrary and could be weighted differently.

| **Access to Economic Resources** | **Assigned Value** | **Actual Participation Score** |
|---|---|---|
| INCOME GENERATION | | |
| Had access to income generation **before** RS | 1 | |
| Have access to income generation **apart from** RS | 1 | |
| Have access to income generation **only through** RS | 1 | |
| Have increased access to income generation **through** RS | 1 | |
| CREDIT | | |
| Had access to credit **before** RS | 1 | |
| Have access to credit **apart from** RS | 1 | |
| Have access to credit **only through** RS | 1 | |
| Have increased access to credit **through** RS | 1 | |
| MARKET ACCESS | | |
| Had access to markets **before** RS | 1 | |
| Have access to markets **apart from** RS | 1 | |
| Have access to markets **only through** RS | 1 | |
| Have increased access to markets **through** RS | 1 | |
| **Woman's Access to Economic Resources** | | |

A score for the **degree of women's access to economic resources** should be calculated at the time of the interview for each female household member interviewed for the baseline. The score should be recalculated each time the baseline survey questionnaire (as a repeated measure) or a similar monitoring instrument is administered.

### Access to Empowering Skills through ReproSalud

An implicit assumption in the hypotheses of ReproSalud's conceptual framework is that women will become increasingly empowered as they participate in the programmatic sequence and, where available, participate in the increased access to economic resources component of ReproSalud activities. However, it is possible to explicitly identify select skills or training opportunities

associated with ReproSalud activities and develop a variable that could be called **degree of woman's access to empowering skills training *(MUPARDES: Participación de la mujer en desarrollo de destrezas***). This variable attempts to tease out or isolate the more empowering elements embedded within the participatory processes and activities. As with the other independent variables proposed, the values assigned for the skills are arbitrary and could be weighted differently.

| Types of Skills | Value Assigned | Actual Participation Score |
|---|---|---|
| Development of negotiating skills | | |
| • total of up to two hours of training | 1 | |
| • two to up to four hours of training | 2 | |
| • four to up to six hours of training | 3 | |
| • six hours or more of training | 4 | |
| Administrative and financial management | | |
| • member of subproject nucleo, but not treasurer | 1 | |
| • member of subproject nucleo as treasurer | 2 | |
| • coordinator of local product development group | 2 | |
| • member of communal bank | 1 | |
| • member of coordinating committee of communal bank | 2 | |
| Other | | |
| **Woman's Total Empowering Skills Score** | | |

A score for the degree of woman's access to empowering skills training should be calculated at the time of the interview for each female household member interviewed for the baseline. The score should be recalculated each time the baseline survey questionnaire (as a repeated measure), or a similar monitoring instrument, is administered.

**Degree of Involvement of Male Partners**

Ideally increased recognition of the importance of women's health should be acknowledged both by the woman and her partner to facilitate achieving ReproSalud's proposed outcomes. A variable such as the following, that could be called **degree of involvement of partners or spouses in select ReproSalud activities *(HOPARGEN: Particpación del hombre/pareja en***

***actividades generales de ReproSalud)***, would be useful to help measure the relative involvement of men. As in the other proposed independent variables for participation, the values assigned are arbitrary and could be weighted differently.

| Types of Activities Involving Men in Reprosalud | Value Assigned | Actual Involvement |
|---|---|---|
| Attended the informational session prior to project initiation at district level | 1 | |
| Attended the second public session giving the results of the *autodiagnóstico* | 1 | |
| Participated in one or more men's training activities | 1 | |
| • totaling less than four hours | 2 | |
| • totaling between four and eight hours | 3 | |
| • totaling more than eight hours | | |
| **Total Points for Man's Participation** | | |

A score for the degree of partner's involvement in ReproSalud activities should be calculated at the time of the interview for each male household member interviewed for the baseline. The score should be recalculated each time the baseline survey (as a repeated measure), or a similar monitoring instrument, is administered.

## APPENDIX F

### Existing Sources of Data on ReproSalud

The ReproSalud Project has already generated a large amount of data. For the most part, this data collection was designed to support project development, not evaluation. Existing sources of data include:

***Project documents and guides***. Existing project documents describe the framework, objectives, and strategies of the project. These include the Project Paper, papers developed for external meetings, the project's newsletter, and various implementation guides that describe the content and methodology for the implementation of each step of the reproductive health and income-generating components, including *autodiagnóstico*, writing the *autodiagnóstico* report, designing the subproject, management training of subproject administrators, reproductive health training (of particular interest here for women's empowerment is the module on sexuality and gender), applying the entrance and exit exam for community promotors, subproject evaluation, and village banking.

In addition, information is being collected on individual participants, groups, and communities in conjunction with project implementation, including the following:

***Situational analysis***. In each district selected, ReproSalud has conducted a situational analysis in which the information is gathered on women's CBOs. Such information includes whether they exist; number of women's CBOs; level of autonomy and centralization; relationships with other organizations; whether they are organizations dedicated to survival needs; what activities they are carrying out; characteristics of members and information on health services, such as how many, staffing, services offered, relationships with women clients, and existence of programs in reproductive health and family planning. ReproSalud staff also meet with local officials and gather data on how the district is governed, from the perspective of women.

***Selection of CBOs.*** In the CBO selection process, the CBOs who decide to compete for participation in ReproSalud complete a form in which they provide information about the history of their organization, leadership and their activities.

***Autodiagnósticos and five complimentary studies.*** The research team in ReproSalud's Reproductive Health Technical Unit has been gathering extensive data on poor and marginalized women in rural and peri-urban areas, including information about their experiences and perceptions of reproductive health, socioeconomic conditions, and gender roles and relations. Leading the data gathering and analysis are Carmen Yon, the principal social science researcher on the ReproSalud project staff, and Maria Rosa Garate, In-Country Advisor at the Population Council in Lima. These individuals have extensive experience in qualitative research on reproductive health and gender.

a. In *autodiagnóstico* sessions, information is generated, discussed, and analyzed by the participants. A report is later produced on each *autodiagnóstico* based on the regional promotors' notes and taped transcripts.

b. The material in these reports is coded by theme and entered into NUDIST, a text-based database program. The major themes include the three main reproductive health problems identified by participants in ReproSalud—too many children, problems with pregnancy and delivery, and vaginal infections—as well as gender, domestic violence, and perceptions and relationships with the health services.

c. The ReproSalud central office team (and, recently, Carmen Yon in particular) has been working intensively with the regional staff to strengthen the conduct and documentation of the *autodiagnóstico*. If systematically documented, her observations and follow-up work should provide valuable data on the implementation process.

d. Maria Rosa Garate and Carmen Yon, are preparing comprehensive, in-depth analyses on a few selected *autodiagnósticos* (which have thorough notes and video and ausiotaped transcripts).

e. ReproSalud has written a booklet using the information that emerged from the autodiagnosticos on domestic violence: "No one knows what happens in my house, only I know my pain…"

f. Five complementary studies have been planned so far. They focus on the three main reproductive health problems identified in the autodiagnostico sessions—vaginal infections, problems associated with pregnancy and childbirth, and unwanted fertility—and two additional topics: women's interactions with health services, and gender relations (and the connection with reproductive health). These studies are to be contracted out and conducted by independent research teams.

Several of these studies are currently underway:

- **Vaginal infections**. An epidemiological study of genital tract infections and abnormal pap smears in areas where ReproSalud is currently working is being conducted by a team from the University of Washington's Center for AIDs and STDs. The team is headed by Dr. Patricia Garcia. Preliminary results from four CBOs in two areas show a high prevalence of cervicitis and other STDs (between 34 and 65 percent of women sampled). Seven of 72 women examined in the Pucallpa region were found to have abnormal paps. (Garcia, 13/02/98)

- **Men as partners in health**. A qualitative study of the women's partners is being conducted by a team of Peruvians coordinated by Maria Rosa Garate of the Population Council office in Lima. Three sites have been selected for an in-depth

study of topics that include men's roles as husbands and fathers, roots of domestic violence, and opposition to the use of contraceptives and health services (Population Council, 1997). Results of that study will be available in September 1998.

***Subprojects.*** The steering committee of each subproject submits monthly reports describing its activities, including meetings with local officials and health services personnel. Pre- and post tests to assess what the participants have learned are applied at the beginning and end of the reproductive health training courses. In the community promotor training courses, they are applied by the regional promotor. In the replications with community members course, they are applied by the community promotor.

***Baseline/follow-up surveys.*** These surveys include questions related to women's empowerment, sociodemographic variables, and variables related to reproductive health. Starting in November 1997, they have been administered to participating CBO members, members of their households, and samples of women from nonparticipating households in project sites. Only individuals of reproductive age are interviewed.

***Subproject evaluations.*** The first subprojects were completed in January of 1998, and the first evaluations of subprojects were conducted in February 1998. Only two subprojects have been evaluated up to this point. The subproject evaluation compiles data on three areas: the CBO's activities with local officials and health professionals, the subproject steering committee's financial and administrative management of the subproject, and educational outcomes among CBO promotors and participants in the replication activity. The first subproject evaluations were conducted by Alejandro Bardales, and subsequent evaluations are being conducted by the regional staff.

***Anna-Britt Coe's research.*** Anna-Britt Coe has conducted field research on the ReproSalud project for her Master's thesis in Social Policy using participant observation of project activities and qualitative interviewing with ReproSalud staff and participants. The results will be available at the end of April 1998 and will include a systematic description of the project, the project implementation process (limits, weaknesses, strengths, and results so far—from the perspective of staff members), and mini-case studies of two focus communities where ReproSalud is being implemented (from the perspectives of participants).

In summary, a substantial amount of data has already been collected (or is now being collected). Although the quality and consistency of those data vary, we believe that much can be culled from it. Subsequent studies should focus on documenting changes.

## APPENDIX G

### Chronology and Events of the *Autodiagnóstico* Sessions

The *autodiagnóstico* method as currently being implemented includes four half-day sessions led by a trained facilitator. Activities during each day's sessions are described below.

**Day 1:** The women divide into age-specific groups. Each group develops a life history for a typical woman in the community from birth to old age. The groups are asked to describe this women's life experiences in childhood, adolescence, adulthood, and old age. The groups present their life histories in a plenary session. The facilitator makes note of critical events and experiences that shape the lives of the women described. Participants comment on the fictional life experiences and relate them to their own and other women's lives in their communities. Following the life histories, participants respond to the question "what characterizes a happy woman?"

**Day 2**: Women divide again into their groups to discuss different processes in their reproductive lives. Young women discuss menstruation and contraception, middle-aged women discuss pregnancy and childbirth, and older women discuss menopause. They describe the processes physiologically and discuss their own life experiences, problems, and ways of confronting those experiences and problems in their communities. To facilitate description of the reproductive processes, each group draws their conception of the reproductive organs and how they function during the respective processes they are to discuss. The groups present a summary of their discussion in a plenary session. The participants comment and elaborate on the presentations. At the end of Day 2, the participants are asked to identify the major reproductive health problems in their communities. They spend time identifying those problems women experience most frequently and those considered to be most serious. They identify symptoms and what they are called, the causes of the problems, and how they are treated. In preparation for Day 3, the facilitators ask each women to interview other women in the community about health problems they believe occur most frequently and are most serious. They each receive posters with vivid pictures of women with many of these problems. They are asked to place a sticker on each picture that represents common and serious problems cited by the women they interview.

**Day 3:** The participants analyze the information they have gathered from their fellow community members. The women compare the problems identified in the community with problems they listed the day before. They then prioritize the problems by selecting the three cards containing the problems they consider to affect the largest number of women and that are most critical. The card given the most votes is considered their primary health problem.

**Day 4:** During the last day, the women focus on what they know about the main problem they have selected and generate ideas about how to address it. The facilitators guide the women through the development of a "problem tree" that depicts the causes of the problem in the roots and the effects in the branches. The women then break into groups to draw maps of their

communities that include available institutional and natural resources. They trace routes to follow that will lead them to a solution to their problem. In a plenary session, each group describes each stage of the problem, the point at which they were able to use their own resources to address the problem, when they had to search for other resources, and whether a woman was able to address her problem alone or needed to ask for help from others within and outside of her community. This exercise prepares the way for the next phase of project activities, which is to develop a subproject to address the problem the women have selected. At the end of this session, the participants evaluate the entire experience.

## APPENDIX H

### Determination of Minimum Sample Size within Communities

The sample size estimated for communities was based on the following formula[1]:

n = estimated sample size
t = level of probability (1.96 or $\alpha$ = .05 )
d = confidence interval (.10)
N = size of population (160)
p = value of the estimator (.447)

In Ucayali, the estimated value of contraceptive prevalence is .447[2]

The formula we use to calculate the minimum sample size is the following:

$$n = \frac{t^2 PQ / d^2}{1 + 1/N (t^2 PQ/d^2 - 1)} = 60.77$$

In Huancavelica, the estimated value of contraceptive prevalence is .129[3]. In this case, the minimum sample size using the same formula is 45.

[1] Cochran, W. (1963). Sampling Techniques. NY: Wiley p. 75.
[2] Resultados de la Encuesta Demografica y de Salud Familiar 1996: Ucayali. Lima, Peru: INEI. p. 97.
[3] Resultados de la Encuesta Demografica y de Salud Familiar 1996: Huancavelica. Lima, Peru: INEI. p.103.